

Section 5.1

#13 If the Offeror previously participated in NYSHIP, provide the total appeals filed by, or on behalf of NYSHIP Members for the previous plan year. Please provide the number of upheld, denied, and modified internal and external appeals. For internal appeals, HMOs must provide a breakdown of appeals by administrative and clinical categories.

Question:	Total
Total Appeals filed by, or on behalf of NYSHIP Members for 2019	105
Total number of upheld, denied and modified internal appeals	35
Total number of upheld, denied and modified external appeals	1
Total administrative appeals	101
Total clinical appeals	4

Filed by Capital District Physicians' Health Plan, Inc.



National Committee for Quality Assurance has awarded

Capital District Physicians' Health Plan, Inc. (CDPHP)

Commercial HMO

its highest accreditation status of

Excellent



for service and clinical quality that meet or exceed NCQA's rigorous requirements for consumer protection and quality improvement.

This organization's HEDIS results are in the highest range of national performance.



CHAIR, BOARD OF DIRECTORS

PRESIDENT

CHAIR, REVIEW OVERSIGHT COMMITTEE

05/24/2018

05/24/2021

DATE GRANTED

EXPIRATION DATE



National Committee for Quality Assurance has awarded

Capital District Physicians' Health Plan, Inc. (CDPHP)

Medicare HMO

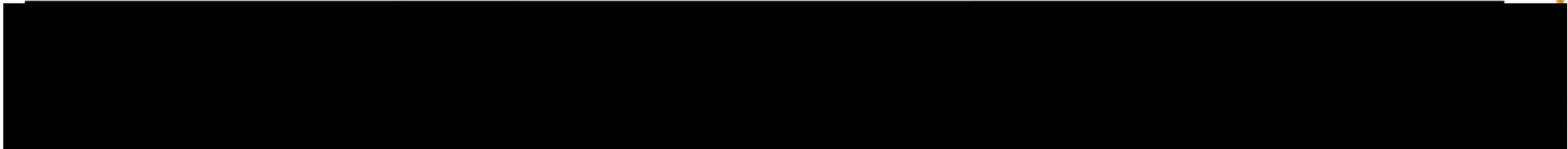
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ATTACHMENT 14



NEW YORK
STATE OF
OPPORTUNITY

**Department of
Civil Service**

**Prescription Drug Benefit (Commercial Plan)
form - "Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program"**

Offeror Name: Capital District Physicians' Health Plan, Inc.

INSTRUCTIONS: Complete the following charts and answer the following questions as applicable to the prescription drug programs proposed for NYSHIP using the definitions on the final pages of this Attachment.

Commercial Formulary (<i>indicate using X in appropriate category</i>)							
Type of Formulary Offered (Indicate only one)							
Open ⁽¹⁾	Incented ⁽²⁾			Closed ⁽³⁾			
				X			
Copayments for 30-day supply and 31to 90-day supply							
If not available at specific pharmacy type put a "N/A" in appropriate box	Retail Acute	Retail Maintenance	Mail Order	Specialty Pharmacy			
30-Day Supply							
Tier 1 Generic	\$5	\$5	\$12.50	\$5			
Tier 2 Preferred-Brand	\$30	\$30	\$75	\$30			
Tier 3 Non-Preferred	\$50	\$50	\$125	\$50			
Specialty	N/A	N/A	N/A	N/A			
31to 90-Day Supply							
Tier 1 Generic	N/A	N/A	\$12.50	\$15			
Tier 2 Preferred-Brand	N/A	N/A	\$75	\$90			
Tier 3 Non-Preferred	N/A	N/A	\$125	\$150			
Specialty	N/A	N/A	N/A	N/A			
Cost Containment/Care Management Strategies (<i>indicate using X in appropriate category</i>)							
Mandatory Generic Requirement ⁽¹⁾	Prior Authorization ⁽²⁾	Step Therapy ⁽³⁾	Dose Optimization ⁽⁴⁾	Half Tab Program ⁽⁵⁾	OTC Program ⁽⁶⁾	Generic Trial Program ⁽⁷⁾	Other (Please Describe)
	X	X					

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NEW YORK
STATE OF
OPPORTUNITY

**Department of
Civil Service**

**Prescription Drug Benefit (Commercial Plan)
form - "Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program"**

Medicare Part D Formulary (<i>indicate using X in appropriate category</i>)							
Type of Formulary Offered (Indicate only one)							
Open ⁽¹⁾	Incented ⁽²⁾	Closed ⁽³⁾					
		X					
Copayments for 30-day supply and 31to 90-day supply							
If not available at specific pharmacy type put a "N/A" in appropriate box	Retail In Network Acute	Retail-Maintenance	Mail Order	Specialty Pharmacy			
30-Day Supply							
Tier 1 Preferred Generic	\$2	N/A	\$2	N/A			
Tier 2 Generic Preferred Brand	\$10	N/A	\$10	N/A			
Tier 3 Preferred Brand Non-Preferred	\$30	N/A	\$30	N/A			
Tier 4 Non-Preferred Drug Specialty	\$50	N/A	\$50	N/A			
Tier 5 Specialty	\$55	N/A	\$55	N/A			
31to 90-Day Supply							
Tier 1 Preferred Generic	\$6	N/A	\$4	N/A			
Tier 2 Generic Preferred Brand	\$30	N/A	\$20	N/A			
Tier 3 Preferred Brand Non-Preferred	\$90	N/A	\$60	N/A			
Tier 4 Non-Preferred Drug Specialty	\$150	N/A	\$100	N/A			
Tier 5 Specialty	N/A	N/A	N/A	N/A			
Cost Containment/Care Management Strategies (<i>indicate using X in appropriate category</i>)							
Mandatory Generic Requirement ⁽¹⁾	Prior Authorization ⁽²⁾	Step Therapy ⁽³⁾	Dose Optimization ⁽⁴⁾	Half Tab Program ⁽⁵⁾	OTC Program ⁽⁶⁾	Generic Trial Program ⁽⁷⁾	Other (Please Describe)
	X	X					

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**Prescription Drug Benefit (Commercial Plan)
form - "Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program"**

1. How often are changes typically made to your prescription drug formulary? Describe how formulary changes are communicated to HMO providers and Enrollees.

The formulary can have up to 5 changes during a year based on decisions made by the Pharmacy and Therapeutic (P&T) Committee of CDPHP. If a drug is removed from the formulary and a generic product for it does not remain covered, members and providers will receive a notification 90 days prior to the change. The removal of drugs from the formulary or revision of a drug tier status is a function of the CDPHP Pharmacy & Therapeutics committee and is subject to clinical/economic review and practitioner/enrollee notification no less than 90 days prior to this action for an exclusion or 30 days for a negative tier change. CDPHP communicates to members via postal mail in regards to changes in their formulary and to providers when a drug is excluded. For formulary changes with high member impact, CDPHP contacts prescribing providers to identify affected members and to make the provider aware of what alternative choices remain on the member's formulary. The physician engagement specialists inform the individual offices/physicians of their specific members that will be affected by this change. The physician engagement and pharmacy department also call upon the top dispensing pharmacies in our network to educate them on these changes and answer any questions they may have. Faxed communications are also sent to pharmacies to make sure they are aware of these changes. CDPHP can also create custom messaging for the point of dispensing to alert the pharmacist of covered formulary alternatives. Members and providers have the right to submit a medical exception request which will be reviewed for medical necessity of a drug no longer covered.

The Medicare Part D formulary can be updated monthly from February to December. Most monthly updates are additions of new drugs or new generics. There are limited negative changes that can be made to the Part D formulary and all need to be first approved by CMS. Typically CDPHP makes negative changes once or sometimes twice a year in the spring and fall. These changes are typically the removal of a brand product when a new generic becomes available. If a drug is removed from the formulary, members and providers will receive a notice 30 days prior to the change. CDPHP provides written notification to members via our PBM at least 30 days in advance of the change. CDPHP also sends a fax blast of any negative changes to our physician network and our PBM also sends a fax blast to the pharmacy network at least 30 days in advance of the change. The negative change formulary letters give members the option to submit

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**Prescription Drug Benefit (Commercial Plan) form - "Health Maintenance Organizations Specifications for the New York State Health Insurance Program"**

a coverage determination that will be reviewed by the pharmacy department if there is a medically necessary reason for the member to remain on the brand product

2. Are Members allowed to purchase a 90-day supply of maintenance medication at a participating retail pharmacy or only through mail order? If maintenance medications can be purchased at a retail pharmacy, state any supply limitations. In addition, describe the copayment structure applied to retail and/or mail order purchases for maintenance medications.

For maintenance medications, members can obtain a 90 day supply thru mail order. At the retail setting, there is a limit of 30 day supply; with the exception of drugs listed on the RxForLess program (see flyer below) - where a member can obtain up to the higher of maximum days' supply allowed or the maximum quantity allowed for the particular drug at an approved RxForLess Pharmacy. As an example a select RxForLess Maintenance drug has a Maximum Days' Supply of 60 and Maximum Quantity of 100. A member taking this maintenance medication once a day could get 100 quantity for a 100 day supply. If a member is taking this maintenance medication twice a day they could obtain 120 quantity for a 60 day supply.

<https://www.cdphp.com/-/media/files/home/rx-for-less.pdf>

3. If HMO utilizes Mandatory Generic Requirement as a cost containment strategy, describe the generic appeals procedure, if one is available, and how generic appeals information is communicated to Enrollees.
CDPHP does not have a mandatory generic requirement.
4. Does HMO's prescription drug benefit have separate requirements or limitations for "specialty medications?" If so, define "specialty medications" and describe the process Members must use to obtain specialty medications, including whether specialty medications must be purchased through a designated Specialty Pharmacy, supply limitations or other restrictions. If specialty medications are required to be purchased through a designated Specialty Pharmacy, has the HMO implemented specialty prescription drug fulfillment hardship exception criteria?

Specialty pharmaceuticals are used in the management of complex chronic or genetic conditions and certain catastrophic diseases such as rheumatoid arthritis, multiple sclerosis, growth hormone deficiency or hepatitis C. They are often injectable medications, but they may also include oral agents. CDPHP has chosen CVS Caremark Specialty Pharmacy Services to dispense certain high-cost injectable and biotech drugs for its members. Eligible members will need to register and will receive a 30 day supply of medications and additional supplies needed to administer the medications. Medications can be sent to a

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Department of
Civil Service

**Prescription Drug Benefit (Commercial Plan)
form - “Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program”**

member’s home, an alternate address selected by the member, a provider’s office or picked up at most local CVS pharmacies.

There are three different options for contacting CVS Caremark Specialty Services: by phone, toll-free at 1- 800-237-2767, by fax toll-free at 1-800-323-2445, or online at <http://www.caremark.com>. In order to provide members with a local option to fill specialty medications, CDPHP made a provision in the PBM contract to allow some of the more commonly used specialty medications to be dispensed by Price Chopper, a large, regional supermarket pharmacy chain which has dual accreditation from URAC and ACHC. While CDPHP has not implemented specialty prescription drug fulfillment hardship exception criteria per se, however; one time overrides are done when appropriate to allow a local fill in cases of emergencies like a dose change, etc.

In addition, as part of the CDPHP Specialty Medication Management Program, CDPHP pharmacists monitor various specialty medications’ utilization, (including new Humira and Enbrel prescriptions) which may include outreach to members, prescribing providers, and the specialty pharmacy to ensure safe, effective, and efficient use.

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**Prescription Drug Benefit (Commercial Plan)
form - “Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program”****Definitions****Formulary:**

- (1) Open or Incented Formulary: The HMO provides coverage for all medications regardless of whether or not they are listed on the formulary. However, some drugs such as those for cosmetic use or over-the-counter drugs may be excluded from coverage. Members may incur additional out of pocket expenses for using non-formulary drugs.
- (2) Closed Formulary: Non-formulary drugs are not reimbursed by the HMO. Administrative procedures are used to allow reimbursement for and access to non-formulary medications where medically appropriate.

Cost Containment Features:

- (1) Mandatory Generic Requirement – When a generic drug is available, the HMO covers only the cost of the generic. If the member requests the brand name when a generic is available, an additional payment is required. This additional payment represents the cost difference between the generic and brand name.
- (2) Prior Authorization – HMO requires members to receive authorization or approval before benefits will be provided for the prescribed drug.
- (3) Step Therapy (and Fail First Requirements) – HMO requires members to try one or more “prerequisite therapy” drug(s) first before benefits will be provided for another drug.
- (4) Dose Optimization – HMO requires members to switch to a higher once-daily dose of a drug when they are taking multiple daily doses of a lower strength.
- (5) Half Tab Program – A voluntary half tablet/pill splitting program. By submitting a prescription for twice the dosage and half the quantity, with the physician’s directions to take half a tablet at the regularly scheduled time, a member is eligible to receive the medication at half the cost of the regular copayment.

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**Prescription Drug Benefit (Commercial Plan)
form - “Health Maintenance Organizations
Specifications for the New York State Health
Insurance Program”**

- (6) OTC Program – Members allowed to choose specified over-the-counter drugs identical to the prescription version at no cost or at the lowest copay amount.

- (7) Generic Trial Program – HMO covers the first 30-day fill of select generic drugs at no cost to the member.

**CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
500 Patroon Creek Boulevard
Albany, New York 12206-1057
(518) 641-3000**

This is Your

**HEALTH MAINTENANCE ORGANIZATION
CERTIFICATE OF COVERAGE**

Issued by

Capital District Physicians' Health Plan, Inc.

This Certificate of Coverage ("Certificate") explains the benefits available to You under a Group Contract between Capital District Physicians' Health Plan, Inc. (hereinafter referred to as "We", "Us" or "Our") and the Group listed in the Group Contract. This Certificate is not a contract between You and Us. Amendments, riders or endorsements may be delivered with the Certificate or added thereafter.

This Certificate offers You the option to receive Covered Services on two benefit levels:

- 1. In-Network Preferred Benefits.** In-network preferred benefits are the higher level of coverage available. In-network preferred benefits apply when Your care is provided by Preferred Providers in Our CDPHP HMO Network. You should always consider receiving health services first through Our Preferred Providers in Our CDPHP HMO Network.
- 2. In-Network Benefits.** In-network benefits are the lower level of coverage available. In-network benefits apply when Your care is provided by Participating Providers that are not Preferred Providers and are in Our CDPHP HMO Network who are located within Our Service Area. You should always consider receiving health care services first through Preferred Providers and then from Participating Providers that are not Preferred Providers. In-network care and in-network preferred care Covered under this Certificate (including Hospitalization) must be provided, arranged or authorized in advance by Your Primary Care Physician and, when required, approved by Us. In order to receive in-network benefits, You must contact Your Primary Care Physician before You obtain the services, except for services to treat an Emergency or urgent Condition described in the Emergency Services and Urgent Care section of this Certificate.

[¹ Grandfathered Certificate. We believe Your Certificate is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve

certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that Your Certificate may not include certain consumer protections of the Affordable Care Act that apply to other plans [2, **for example, the requirement for the provision of preventive health services without any cost sharing (see the amended Preventive Care section of the Schedule of Benefits below)**]. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to Member Services by calling the number on your identification card. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa. This website has a table summarizing which protections do and do not apply to grandfathered health plans.]

READ THIS ENTIRE CERTIFICATE CAREFULLY. IT DESCRIBES THE BENEFITS AVAILABLE UNDER THE GROUP CONTRACT. IT IS YOUR RESPONSIBILITY TO UNDERSTAND THE TERMS AND CONDITIONS IN THIS CERTIFICATE.

This Certificate is governed by the laws of New York State.

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.

By:

**John D. Bennett, MD, FACC
President and CEO**

If You need foreign language assistance to understand this Certificate, You may call Us at the number on Your ID card.

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SECTION I

Definitions

Defined terms will appear capitalized throughout this Certificate.

Acute: The onset of disease or injury, or a change in the Member's condition that would require prompt medical attention.

Allowed Amount: The maximum amount on which Our payment is based for Covered Services. See the Cost-Sharing Expenses and Allowed Amount section of this Certificate for a description of how the Allowed Amount is calculated.

Ambulatory Surgical Center: A Facility currently licensed by the appropriate state regulatory agency for the provision of surgical and related medical services on an outpatient basis.

Appeal: A request for Us to review a Utilization Review decision or a Grievance again.

Balance Billing: When a Non-Participating Provider bills You for the difference between the Non-Participating Provider's charge and the Allowed Amount. A Participating Provider may not Balance Bill You for Covered Services.

Certificate: This Certificate issued by Capital District Physicians' Health Plan, Inc., including the Schedule of Benefits and any attached riders.

Child, Children: The Subscriber's Children, including any natural, adopted or step-children, unmarried disabled Children, newborn Children, or any other Children as described in the Who is Covered section of this Certificate.

Coinsurance: Your share of the costs of a Covered Service, calculated as a percent of the Allowed Amount for the service that You are required to pay to a Provider. The amount can vary by the type of Covered Service.

Copayment: A fixed amount You pay directly to a Provider for a Covered Service when You receive the service. The amount can vary by the type of Covered Service.

Cost-Sharing: Amounts You must pay for Covered Services, expressed as Copayments, Deductibles and/or Coinsurance.

Cover, Covered or Covered Services: The Medically Necessary services paid for, arranged, or authorized for You by Us under the terms and conditions of this Certificate.

Deductible: The amount You owe before We begin to pay for Covered Services. The Deductible applies before any Copayments or Coinsurance are applied. The Deductible

may not apply to all Covered Services. You may also have a Deductible that applies to a specific Covered Service (e.g., a Prescription Drug Deductible) that You owe before We begin to pay for a particular Covered Service.

Dependents: The Subscriber's Spouse and Children. Additional Dependents are also described in the Who is Covered section of this Certificate.

Durable Medical Equipment ("DME"): Equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Emergency Condition: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person's bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

Emergency Department Care: Emergency Services You get in a Hospital emergency department.

Emergency Services: A medical screening examination which is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Condition; and within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as are required to stabilize the patient. "To stabilize" is to provide such medical treatment of an Emergency Condition as may be necessary to assure that, within reasonable medical probability, no material deterioration of the condition is likely to result from or occur during the transfer of the patient from a Facility, or to deliver a newborn child (including the placenta).

Exclusions: Health care services that We do not pay for or Cover.

External Appeal Agent: An entity that has been certified by the New York State Department of Financial Services to perform external appeals in accordance with New York law.

Facility: A Hospital; Ambulatory Surgical Center; birthing center; dialysis center;

rehabilitation Facility; Skilled Nursing Facility; hospice; Home Health Agency or home care services agency certified or licensed under New York Public Health Law Article 36; a comprehensive care center for eating disorders pursuant to New York Mental Hygiene Law Article 30; and a Facility defined in New York Mental Hygiene Law Section 1.03, certified by the New York State Office of Addiction Services and Supports, or certified under New York Public Health Law Article 28 (or, in other states, a similarly licensed or certified Facility). If You receive treatment for substance use disorder outside of New York State, a Facility also includes one which is accredited by the Joint Commission to provide a substance use disorder treatment program.

Grievance: A complaint that You communicate to Us that does not involve a Utilization Review determination.

Group: The employer or party that has entered into an agreement with Us as a contractholder.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Habilitative Services include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. These services consist of physical therapy, occupational therapy and speech therapy.

Health Care Professional: An appropriately licensed, registered or certified Physician; dentist; optometrist; chiropractor; psychologist; social worker; podiatrist; physical therapist; occupational therapist; midwife; speech-language pathologist; audiologist; pharmacist; behavior analyst; nurse practitioner; or any other licensed, registered or certified Health Care Professional under Title 8 of the New York Education Law (or other comparable state law, if applicable) that the New York Insurance Law requires to be recognized who charges and bills patients for Covered Services. The Health Care Professional's services must be rendered within the lawful scope of practice for that type of Provider in order to be covered under this Certificate.

Home Health Agency: An organization currently certified or licensed by the State of New York or the state in which it operates and renders home health care services.

Hospice Care: Care to provide comfort and support for persons in the last stages of a terminal illness and their families that are provided by a hospice organization certified pursuant to New York Public Health Law Article 40 or under a similar certification process required by the state in which the hospice organization is located.

Hospital: A short term, acute, general Hospital, which:

- Is primarily engaged in providing, by or under the continuous supervision of Physicians, to patients, diagnostic services and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- Has organized departments of medicine and major surgery;

- Has a requirement that every patient must be under the care of a Physician or dentist;
- Provides 24-hour nursing service by or under the supervision of a registered professional nurse (R.N.);
- If located in New York State, has in effect a Hospitalization review plan applicable to all patients which meets at least the standards set forth in 42 U.S.C. Section 1395x(k);
- Is duly licensed by the agency responsible for licensing such Hospitals; and
- Is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational, or rehabilitative care.

Hospital does not mean health resorts, spas, or infirmaries at schools or camps.

Hospitalization: Care in a Hospital that requires admission as an inpatient and usually requires an overnight stay.

Hospital Outpatient Care: Care in a Hospital that usually doesn't require an overnight stay.

Medically Necessary: See the How Your Coverage Works section of this Certificate for the definition.

Medicare: Title XVIII of the Social Security Act, as amended.

Member: The Subscriber or a covered Dependent for whom required Premiums have been paid. Whenever a Member is required to provide a notice pursuant to a Grievance or emergency department visit or admission, "Member" also means the Member's designee.

Network: The Providers We have contracted with to provide health care services to You.

Non-Participating Provider: A Provider who doesn't have a contract with Us to provide health care services to You. The services of Non-Participating Providers are Covered only for Emergency Services, Urgent Care or when authorized by Us.

Out-of-Pocket Limit: The most You pay during a Plan Year in Cost-Sharing before We begin to pay 100% of the Allowed Amount for Covered Services. This limit never includes Your Premium, Balance Billing charges or the cost of health care services We do not Cover.

Participating Provider: A Provider who has a contract with Us to provide health care services to You. A list of Participating Providers and their locations is available on Our website at www.cdphp.com or upon Your request to Us. The list will be revised from time to time by Us. You will pay higher Cost-Sharing to see a Participating Provider as

compared to a Preferred Provider.

Physician or Physician Services: Health care services a licensed medical Physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Plan Year: The 12-month period beginning on the effective date of the Certificate or any anniversary date thereafter, during which the Certificate is in effect.

Preauthorization: A decision by Us prior to Your receipt of a Covered Service, procedure, treatment plan, device, or Prescription Drug that the Covered Service, procedure, treatment plan, device or Prescription Drug is Medically Necessary. We indicate which Covered Services require Preauthorization in the Schedule of Benefits section of this Certificate.

Preferred Provider: A Provider who has a contract with Us to provide health care services to You at the highest level of coverage available to You. You will pay the least amount of Cost-Sharing to see a Preferred Provider.

Premium: The amount that must be paid for Your health insurance coverage.

Prescription Drugs: A medication, product or device that has been approved by the Food and Drug Administration (“FDA”) and that can, under federal or state law, be dispensed only pursuant to a prescription order or refill and is on Our formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.

Primary Care Physician (“PCP”): A participating nurse practitioner or Physician who typically is an internal medicine, family practice or pediatric Physician and who directly provides or coordinates a range of health care services for You.

Provider: A Physician, Health Care Professional, or Facility licensed, registered, certified or accredited as required by state law. A Provider also includes a vendor or dispenser of diabetic equipment and supplies, durable medical equipment, medical supplies, or any other equipment or supplies that are Covered under this Certificate that is licensed, registered, certified or accredited as required by state law.

Referral: An authorization given to one Participating Provider from another Participating Provider (usually from a PCP to a participating Specialist) in order to arrange for additional care for a Member. A Referral can be transmitted electronically or by Your Provider completing a paper Referral form. Except as provided in the Access to Care and Transitional Care section of this Certificate or as otherwise authorized by Us, a Referral will not be made to a Non-Participating Provider.

Rehabilitation Services: Health care services that help a person keep, get back, or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt, or disabled. These services consist of physical therapy, occupational therapy, and speech therapy in an inpatient and/or outpatient setting.

Schedule of Benefits: The section of this Certificate that describes the Copayments, Deductibles, Coinsurance, Out-of-Pocket Limits, Preauthorization requirements, and other limits on Covered Services.

Service Area: The geographical area, designated by Us and approved by the State of New York, in which We provide coverage. Our Service Area consists of the following counties: Albany, Broome, Chenango, [Clinton,] Columbia, Delaware, Dutchess, Essex, [Franklin,] Fulton, Greene, Hamilton, Herkimer, [Jefferson, Lewis,] Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, [St. Lawrence,] Tioga, Ulster, Warren, and Washington.

Skilled Nursing Facility: An institution or a distinct part of an institution that is currently licensed or approved under state or local law; primarily engaged in providing skilled nursing care and related services as a Skilled Nursing Facility, extended care Facility, or nursing care Facility approved by the Joint Commission, or the Bureau of Hospitals of the American Osteopathic Association, or as a Skilled Nursing Facility under Medicare; or as otherwise determined by Us to meet the standards of any of these authorities.

Specialist: A Physician who focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions.

Spouse: The person to whom the Subscriber is legally married, including a same sex Spouse.

Subscriber: The person to whom this Certificate is issued.

UCR (Usual, Customary and Reasonable): The cost of a medical service in a geographic area based on what Providers in the area usually charge for the same or similar medical service.

Urgent Care: Medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care may be rendered in a Physician's office or Urgent Care Center.

Urgent Care Center: A licensed Facility that provides Urgent Care.

Us, We, Our: Capital District Physicians' Health Plan, Inc. and anyone to whom We

legally delegate performance, on Our behalf, under this Certificate.

Utilization Review: The review to determine whether services are or were Medically Necessary or experimental or investigational (i.e., treatment for a rare disease or a clinical trial).

You, Your: The Member.



SECTION II

How Your Coverage Works

A. Your Coverage Under this Certificate.

Your employer (referred to as the “Group”) has purchased a Group health insurance Contract from Us. We will provide the benefits described in this Certificate to covered Members of the Group, that is, to employees of the Group and their covered Dependents. However, this Certificate is not a contract between You and Us. You should keep this Certificate with Your other important papers so that it is available for Your future reference.

B. Covered Services.

You will receive Covered Services under the terms and conditions of this Certificate only when the Covered Service is:

- Medically Necessary;
- Provided by a Preferred or Participating Provider;
- Listed as a Covered Service;
- Not in excess of any benefit limitations described in the Schedule of Benefits section of this Certificate; and
- Received while Your Certificate is in force.

When You are outside Our Service Area, coverage is limited to Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition and Urgent Care.

C. Participating Providers.

To find out if a Provider is a Preferred or Participating Provider:

- Check Our Provider directory, available at Your request;
- Call the number on Your ID card; or
- Visit Our website at www.cdphp.com.

The Provider directory will give You the following information about Our Participating Providers:

- Name, address, and telephone number;
- Specialty;
- Board certification (if applicable);
- Languages spoken;
- Whether the Provider is a Preferred Provider; and
- Whether the Participating Provider is accepting new patients.

D. Preferred Providers.

Some Participating Providers are also Preferred Providers. Certain services may be obtained from Preferred Providers. If You receive Covered Services from Preferred

Providers, Your Cost-Sharing may be lower than if You received the services from Participating Providers. See the Schedule of Benefits section of this Certificate for coverage of Preferred Provider services.

E. The Role of Primary Care Physicians.

This Certificate has a gatekeeper, usually known as a Primary Care Physician (“PCP”). This Certificate requires that You select a Primary Care Physician (“PCP”). You need a Referral from a PCP before receiving Specialist care.

You may select any participating PCP who is available from the list of PCPs in the CDPHP HMO Network. Each Member may select a different PCP. Children covered under this Certificate may designate a participating PCP who specializes in pediatric care. In certain circumstances, You may designate a Specialist as Your PCP. See the Access to Care and Transitional Care section of this Certificate for more information about designating a Specialist. To select a PCP, visit Our website at www.cdphp.com. If You do not select a PCP, We will assign one to You.

For purposes of Cost-Sharing, if You seek services from a PCP (or a Physician covering for a PCP) who has a primary or secondary specialty other than general practice, family practice, internal medicine, pediatrics and OB/GYN, You must pay the specialty office visit Cost-Sharing in the Schedule of Benefits section of this Certificate when the services provided are related to specialty care.

F. Services Not Requiring a Referral from Your PCP.

Your PCP is responsible for determining the most appropriate treatment for Your health care needs. You do not need a Referral from Your PCP to a Participating Provider for the following services:

- Primary and preventive obstetric and gynecologic services including annual examinations, care resulting from such annual examinations, treatment of Acute gynecologic conditions, or for any care related to a pregnancy from a qualified Participating Provider of such services;
- Emergency Services;
- Pre-Hospital Emergency Medical Services and emergency ambulance transportation;
- Maternal depression screening;
- Urgent Care;
- Outpatient mental health care;
- Outpatient substance use services;
- Diabetic eye exams from an ophthalmologist.

However, the Participating Provider must discuss the services and treatment plan with Your PCP; agree to follow Our policies and procedures including any procedures regarding Referrals or Preauthorization for services other than obstetric and gynecologic services rendered by such Participating Provider; and agree to provide services pursuant to a treatment plan (if any) approved by Us. See the Schedule of

Benefits section of this Certificate for the services that require a Referral.

G. Access to Providers and Changing Providers.

Sometimes Providers in Our Provider directory are not available. Prior to notifying Us of the PCP You selected, You should call the PCP to make sure he or she is a Participating Provider and is accepting new patients.

To see a Provider, call his or her office and tell the Provider that You are a CDPHP HMO Member, and explain the reason for Your visit. Have Your ID card available. The Provider's office may ask You for Your Group or Member ID number. When You go to the Provider's office, bring Your ID card with You.

To contact Your Provider after normal business hours, call the Provider's office. You will be directed to Your Provider, an answering machine with directions on how to obtain services, or another Provider. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911.

You may change Your PCP by calling the number on your ID card.

H. Services Subject to Preauthorization.

Our Preauthorization is required before You receive certain Covered Services. Your Participating Provider is responsible for requesting Preauthorization for in-network services.

I. Preauthorization Notification Procedure.

If You seek coverage for services that require Preauthorization, Your Provider must call Us at the number on Your ID card.

After receiving a request for approval, We will review the reasons for Your planned treatment and determine if benefits are available. Criteria will be based on multiple sources which may include medical policy, clinical guidelines, and pharmacy and therapeutic guidelines.

J. Medical Management.

The benefits available to You under this Certificate are subject to pre-service, concurrent and retrospective reviews to determine when services should be Covered by Us. The purpose of these reviews is to promote the delivery of cost-effective medical care by reviewing the use of procedures and, where appropriate, the setting or place the services are performed. Covered Services must be Medically Necessary for benefits to be provided.

K. Medical Necessity.

We Cover benefits described in this Certificate as long as the health care service, procedure, treatment, test, device, Prescription Drug or supply (collectively, "service") is Medically Necessary. The fact that a Provider has furnished, prescribed, ordered,

recommended, or approved the service does not make it Medically Necessary or mean that We have to Cover it.

We may base Our decision on a review of:

- Your medical records;
- Our medical policies and clinical guidelines;
- Medical opinions of a professional society, peer review committee or other groups of Physicians;
- Reports in peer-reviewed medical literature;
- Reports and guidelines published by nationally-recognized health care organizations that include supporting scientific data;
- Professional standards of safety and effectiveness, which are generally-recognized in the United States for diagnosis, care, or treatment;
- The opinion of Health Care Professionals in the generally-recognized health specialty involved;
- The opinion of the attending Providers, which have credence but do not overrule contrary opinions.

Services will be deemed Medically Necessary only if:

- They are clinically appropriate in terms of type, frequency, extent, site, and duration, and considered effective for Your illness, injury, or disease;
- They are required for the direct care and treatment or management of that condition;
- Your condition would be adversely affected if the services were not provided;
- They are provided in accordance with generally-accepted standards of medical practice;
- They are not primarily for the convenience of You, Your family, or Your Provider;
- They are not more costly than an alternative service or sequence of services, that is at least as likely to produce equivalent therapeutic or diagnostic results;
- When setting or place of service is part of the review, services that can be safely provided to You in a lower cost setting will not be Medically Necessary if they are performed in a higher cost setting. For example, We will not provide coverage for an inpatient admission for surgery if the surgery could have been performed on an outpatient basis or an infusion or injection of a specialty drug provided in the outpatient department of a Hospital if the drug could be provided in a Physician's office or the home setting.

See the Utilization Review and External Appeal sections of this Certificate for Your right to an internal Appeal and external appeal of Our determination that a service is not Medically Necessary.

L. Protection from Surprise Bills.

- 1. Surprise Bills.** A surprise bill is a bill You receive for Covered Services in the following circumstances:

- For services performed by a non-participating Physician at a participating Hospital or Ambulatory Surgical Center, when:
 - A participating Physician is unavailable at the time the health care services are performed;
 - A non-participating Physician performs services without Your knowledge; or
 - Unforeseen medical issues or services arise at the time the health care services are performed.

A surprise bill does not include a bill for health care services when a participating Physician is available and You elected to receive services from a non-participating Physician.

- You were referred by a participating Physician to a Non-Participating Provider without Your explicit written consent acknowledging that the referral is to a Non-Participating Provider and it may result in costs not covered by Us. For a surprise bill, a referral to a Non-Participating Provider means:
 - Covered Services are performed by a Non-Participating Provider in the participating Physician's office or practice during the same visit;
 - The participating Physician sends a specimen taken from You in the participating Physician's office to a non-participating laboratory or pathologist; or
 - For any other Covered Services performed by a Non-Participating Provider at the participating Physician's request, when Referrals are required under Your Certificate.

You will be held harmless for any Non-Participating Provider charges for the surprise bill that exceed Your Copayment, Deductible or Coinsurance if You assign benefits to the Non-Participating Provider in writing. In such cases, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance.

The assignment of benefits form for surprise bills is available at www.dfs.ny.gov or You can visit Our website at www.cdphp.com for a copy of the form. You need to mail a copy of the assignment of benefits form to Us at the address on Our website and to Your Provider.

- 2. Independent Dispute Resolution Process.** Either We or a Provider may submit a dispute involving a surprise bill to an independent dispute resolution entity ("IDRE") assigned by the state. Disputes are submitted by completing the IDRE application form, which can be found at www.dfs.ny.gov. The IDRE will determine whether Our payment or the Provider's charge is reasonable within 30 days of receiving the dispute.

M. Delivery of Covered Services Using Telehealth.

If Your Participating Provider offers Covered Services using telehealth, We will not deny the Covered Services because they are delivered using telehealth. Covered Services delivered using telehealth may be subject to utilization review and quality assurance requirements and other terms and conditions of the Certificate that are at least as favorable as those requirements for the same service when not delivered using telehealth. "Telehealth" means the use of electronic information and communication technologies by a Participating Provider to deliver Covered Services to You while Your location is different than Your Provider's location.

N. Early Intervention Program Services.

We will not exclude Covered Services solely because they are Early Intervention Program services for infants and toddlers under three years of age who have a confirmed disability or an established developmental delay. Additionally, if Early Intervention Program services are otherwise covered under this Certificate, coverage for Early Intervention Program services will not be applied against any maximum annual or lifetime dollar limits if applicable. Visit limits and other terms and conditions will continue to apply to coverage for Early Intervention Program services. However, any visits used for Early Intervention Program services will not reduce the number of visits otherwise available under this Certificate.

O. Care Management

Care management helps coordinate services for Members with health care needs due to serious, complex, and/or chronic health conditions. Our programs coordinate benefits and educate Members who agree to take part in the case management program to help meet their health-related needs.

Our care management programs are confidential and voluntary. These programs are given at no extra cost to You and do not change Covered Services. If You meet program criteria and agree to take part, We will help You meet Your identified health care needs. This is reached through contact and team work with You and/or Your authorized representative, treating Physician(s), and other Providers. In addition, We may assist in coordinating care with existing community-based programs and services to meet Your needs, which may include giving You information about external agencies and community-based programs and services.

In certain cases of severe or chronic illness or injury, We may provide benefits for alternate care through Our care management program that is not listed as a Covered Service. We may also extend Covered Services beyond the benefit maximums of this Certificate. We will make Our decision on a case-by-case basis if We determine the alternate or extended benefit is in the best interest of You and Us.

Nothing in this provision shall prevent You from appealing Our decision. A decision to provide extended benefits or approve alternate care in one case does not obligate Us to provide the same benefits again to You or to any other Member. We reserve the right, at any time, to alter or stop providing extended benefits or approving alternate

care. In such case, We will notify You or Your representative in writing.

P. Important Telephone Numbers and Addresses.

- CLAIMS
- CDPHP, PO Box 66602, Albany, NY 12206
(Submit claim forms to this address.)

Log-in to the secure member portal at www.cdphp.com and select the “Mail Center” icon to submit claims via secure email.
(Submit electronic claim forms to this e-mail address.)

- COMPLAINTS, GRIEVANCES AND UTILIZATION REVIEW APPEALS
Call the number on Your ID card
- ASSIGNMENT OF BENEFITS FORM
Refer to the address on Your ID card
(Submit assignment of benefits forms for surprise bills to this address.)
- MEMBER SERVICES
Call the number on Your ID card
(Member Services Representatives are available Monday - Friday, 8:00 a.m. – 5:00 p.m.)
- PREAUTHORIZATION
Call the number on Your ID card
- BEHAVIORAL HEALTH SERVICES
Call the number on Your ID card
- OUR WEBSITE
www.cdphp.com

SECTION III

Access to Care and Transitional Care

A. Referral to a Non-Participating Provider.

If We determine that We do not have a Participating Provider that has the appropriate training and experience to treat Your condition, We will approve a Referral to an appropriate Non-Participating Provider. Your Participating Provider must request prior approval of the Referral to a specific Non-Participating Provider. Approvals of Referrals to Non-Participating Providers will not be made for the convenience of You or another treating Provider and may not necessarily be to the specific Non-Participating Provider You requested. If We approve the Referral, all services performed by the Non-Participating Provider are subject to a treatment plan approved by Us in consultation with Your PCP, the Non-Participating Provider and You. Covered Services rendered by the Non-Participating Provider will be covered as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. In the event a Referral is not approved, any services rendered by a Non-Participating Provider will not be Covered.

B. When a Specialist Can Be Your Primary Care Physician.

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may ask that a Specialist who is a Participating Provider be Your PCP. We will consult with the Specialist and Your PCP and decide whether the Specialist should be Your PCP. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. We will not approve a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved treatment plan will be paid as if they were provided by a Participating Provider. You will only be responsible for any applicable in-network Cost-Sharing.

C. Standing Referral to a Participating Specialist.

If You need ongoing specialty care, You may receive a standing Referral to a Specialist who is a Participating Provider. This means that You will not need a new Referral from Your PCP every time You need to see that Specialist. We will consult with the Specialist and Your PCP and decide whether You should have a standing Referral. Any Referral will be pursuant to a treatment plan approved by Us in consultation with Your PCP, the Specialist and You. The treatment plan may limit the number of visits, or the period during which the visits are authorized and may require the Specialist to provide Your PCP with regular updates on the specialty care provided as well as all necessary medical information. We will not approve a standing Referral to a non-participating Specialist unless We determine that We do not have an appropriate Provider in Our network. If We approve a standing Referral to a non-participating Specialist, Covered Services rendered by the non-participating Specialist pursuant to the approved

treatment plan will be paid as if they were provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

D. Specialty Care Center.

If You have a life-threatening condition or disease or a degenerative and disabling condition or disease that requires specialty care over a long period of time, You may request a Referral to a specialty care center with expertise in treating Your condition or disease. A specialty care center is a center that has an accreditation or designation from a state agency, the federal government or a national health organization as having special expertise to treat Your disease or condition. We will consult with Your PCP, Your Specialist, and the specialty care center to decide whether to approve such a Referral. Any Referral will be pursuant to a treatment plan developed by the specialty care center, and approved by Us in consultation with Your PCP or Specialist and You. We will not approve a Referral to a non-participating specialty care center unless We determine that We do not have an appropriate specialty care center in Our network. If We approve a Referral to a non-participating specialty care center, Covered Services rendered by the non-participating specialty care center pursuant to the approved treatment plan will be paid as if they were provided by a participating specialty care center. You will be responsible only for any applicable in-network Cost-Sharing.

E. When Your Provider Leaves the Network.

If You are in an ongoing course of treatment when Your Provider leaves Our network, then You may be able to continue to receive Covered Services for the ongoing treatment from the former Participating Provider for up to 90 days from the date Your Provider's contractual obligation to provide services to You terminates. If You are pregnant and in Your second or third trimester, You may be able to continue care with a former Participating Provider through delivery and any postpartum care directly related to the delivery.

In order for You to continue to receive Covered Services for up to 90 days or through a pregnancy with a former Participating Provider, the Provider must agree to accept as payment the negotiated fee that was in effect just prior to the termination of Our relationship with the Provider. The Provider must also agree to provide Us necessary medical information related to Your care and adhere to our policies and procedures, including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing. Please note that if the Provider was terminated by Us due to fraud, imminent harm to patients or final disciplinary action by a state board or agency that impairs the Provider's ability to practice, continued treatment with that Provider is not available.

F. New Members In a Course of Treatment.

If You are in an ongoing course of treatment with a Non-Participating Provider when Your coverage under this Certificate becomes effective, You may be able to receive

Covered Services for the ongoing treatment from the Non-Participating Provider for up to 60 days from the effective date of Your coverage under this Certificate. This course of treatment must be for a life-threatening disease or condition or a degenerative and disabling condition or disease. You may also continue care with a Non-Participating Provider if You are in the second or third trimester of a pregnancy when Your coverage under this Certificate becomes effective. You may continue care through delivery and any post-partum services directly related to the delivery.

In order for You to continue to receive Covered Services for up to 60 days or through pregnancy, the Non-Participating Provider must agree to accept as payment Our fees for such services. The Provider must also agree to provide Us necessary medical information related to Your care and to adhere to Our policies and procedures including those for assuring quality of care, obtaining Preauthorization, Referrals, and a treatment plan approved by Us. If the Provider agrees to these conditions, You will receive the Covered Services as if they were being provided by a Participating Provider. You will be responsible only for any applicable in-network Cost-Sharing.

SECTION IV

Cost-Sharing Expenses and Allowed Amount

A. [³ Deductible.

There is no Deductible for Covered Services under this Certificate during each Plan Year.]

[⁴ Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, the individual Deductible applies to each person covered under this Certificate. Once a person within a family meets the individual Deductible, no further Deductible is required for the person that has met the individual Deductible for that Plan Year. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

[⁵ Deductible.

Except where stated otherwise, You must pay the amount in the Schedule of Benefits section of this Certificate for Covered Services during each Plan Year before We provide coverage. If You have other than individual coverage, You must pay the family Deductible in the Schedule of Benefits section of this Certificate for Covered Services under this Certificate during each Plan Year before We provide coverage for any person covered under this Certificate. However, after Deductible payments for persons covered under this Certificate collectively total the family Deductible amount in the Schedule of Benefits section of this Certificate in a Plan Year, no further Deductible will be required for any person covered under this Certificate for that Plan Year.

In-network Cost-Sharing amounts to which a Deductible applies accumulate toward both the Deductibles for Preferred Providers and for Participating Providers.

B. Copayments.

Except where stated otherwise, [⁶ after You have satisfied the Deductible as described above,] You must pay the Copayments, or fixed amounts, in the Schedule of Benefits section of this Certificate for Covered Certificate Services. However, when the Allowed Amount for a service is less than the Copayment, You are responsible for the lesser amount.

C. Coinsurance.

Except where stated otherwise, [⁷ after You have satisfied the Deductible described above,] You must pay a percentage of the Allowed Amount for Covered Services. We will pay the remaining percentage of the Allowed Amount as Your benefit as shown in the Schedule of Benefits section of this Certificate.

D. Out-of-Pocket Limit.

When You have met Your Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for Covered Services for the remainder of that Plan Year. If You have other than individual coverage, once a person within a family meets the individual Out-of-Pocket Limit in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for that person. If other than individual coverage applies, when persons in the same family covered under this Certificate have collectively met the family Out-of-Pocket Limit in payment of Copayments, Deductibles and Coinsurance for a Plan Year in the Schedule of Benefits section of this Certificate, We will provide coverage for 100% of the Allowed Amount for the rest of that Plan Year for the entire family. In-network Cost-Sharing amounts to which an Out-of-Pocket Limit applies will accumulate toward both the Out-of-Pocket Limits for Preferred Providers and for Participating Providers.

Cost-Sharing for out-of-network services, except for Emergency Services and out-of-network dialysis does not apply toward Your Out-of-Pocket Limit.

E. Allowed Amount.

“Allowed Amount” means the maximum amount We will pay for the services or supplies Covered under this Certificate, before any applicable Copayment, Deductible and Coinsurance amounts are subtracted. We determine Our Allowed Amount as follows:

The Allowed Amount for Participating Providers will be the amount We have negotiated with the Participating Provider, or the Participating Provider’s charge.

Our payments to Participating Providers may include financial incentives to help improve the quality or coordination of care and promote the delivery of Covered Services in a cost-efficient manner. Payments under this financial incentive program are not made as payment for a specific Covered Service provided to You. Your Cost-Sharing will not change based on any payments made to or received from Participating Providers as part of the financial incentive program.

See the Emergency Services and Urgent Care section of this Certificate for the Allowed Amount for Emergency Services rendered by Non-Participating Providers. See the Ambulance and Pre-Hospital Emergency Medical Services section of this Certificate for the Allowed Amount for Pre-Hospital Emergency Medical Services rendered by Non-Participating Providers.

SECTION V

Who is Covered

A. Who is Covered Under this Certificate.

You, the Subscriber to whom this Certificate is issued, are covered under this Certificate. [⁸ You must live, work, or reside in Our Service Area to be covered under this Certificate.] Members of Your family may also be covered depending on the type of coverage You selected.

B. Types of Coverage.

We offer the following types of coverage:

- 1. Individual.** If You selected individual coverage, then You are covered.
- 2. Individual and Spouse.** If You selected individual and Spouse coverage, then You and Your Spouse are covered.
- 3. Parent and Child/Children.** If You selected parent and child/children coverage, then You and Your Child or Children, as described below, are covered.
- 4. Family.** If You selected family coverage, then You and Your Spouse and Your Child or Children, as described below, are covered.

C. Children Covered Under this Certificate.

If You selected parent and child/children or family coverage, Children covered under this Certificate include Your natural Children, legally adopted Children, step Children, and Children for whom You are the proposed adoptive parent without regard to financial dependence, residency with You, student status or employment. A proposed adopted Child is eligible for coverage on the same basis as a natural Child during any waiting period prior to the finalization of the Child's adoption. Coverage lasts until the end of the month in which the Child turns 26 years of age. Coverage also includes Children for whom You are a permanent legal guardian if the Children are chiefly dependent upon You for support and You have been appointed the legal guardian by a court order. Foster children and grandchildren are not covered.

Any unmarried dependent Child, regardless of age, who is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation (as defined in the New York Mental Hygiene Law), or physical handicap and who became so incapable prior to attainment of the age at which the Child's coverage would otherwise terminate and who is chiefly dependent upon You for support and maintenance, will remain covered while Your insurance remains in force and Your Child remains in such condition. You have 31 days from the date of Your Child's attainment of the termination age to submit an application to request that the Child be included in Your coverage and proof of the Child's incapacity. We have the right to check whether a

Child qualifies and continues to qualify under this section.

We have the right to request and be furnished with such proof as may be needed to determine eligibility status of a prospective or covered Subscriber and all other prospective or covered Members in relation to eligibility for coverage under this Certificate at any time.

D. When Coverage Begins.

Coverage under this Certificate will begin as follows:

1. If You, the Subscriber, elect coverage before becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, coverage begins on the date You become eligible, or on the date determined by Your Group. Groups cannot impose waiting periods that exceed 90 days.
2. If You, the Subscriber, do not elect coverage upon becoming eligible, or within 30 days of becoming eligible for other than a special enrollment period, You must wait until the Group's next open enrollment period to enroll, except as provided below.
3. If You, the Subscriber, marry while covered, and We receive notice of such marriage and any Premium payment within 30 days thereafter, coverage for Your Spouse and Child starts on the first day of the following month after We receive Your application. If We do not receive notice within 30 days of the marriage, You must wait until the Group's next open enrollment period to add Your Spouse or Child.
4. If You, the Subscriber, have a newborn or adopted newborn Child and We receive notice of such birth within 30 days thereafter, coverage for Your newborn starts at the moment of birth; otherwise, coverage begins on the date on which We receive notice. Your adopted newborn Child will be covered from the moment of birth if You take physical custody of the infant as soon as the infant is released from the Hospital after birth and You file a petition pursuant to Section 115-c of the New York Domestic Relations Law within 30 days of the infant's birth; and provided further that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the New York Domestic Relations Law, and consent to the adoption has not been revoked. However, We will not provide Hospital benefits for the adopted newborn's initial Hospital stay if one of the infant's natural parents has coverage for the newborn's initial Hospital stay. If You have individual or individual and Spouse coverage, You must also notify Us of Your desire to switch to parent and child/children or family coverage and pay any additional Premium within 30 days of the birth or adoption in order for coverage to start at the moment of birth. Otherwise, coverage begins on the date on which We receive notice, provided that You pay any additional Premium when due.

E. Special Enrollment Periods.

You, Your Spouse or Child can also enroll for coverage within 30 days of the loss of coverage in another group health plan if coverage was terminated because You, Your Spouse or Child are no longer eligible for coverage under the other group health plan

due to:

1. Termination of employment;
2. Termination of the other group health plan;
3. Death of the Spouse;
4. Legal separation, divorce or annulment;
5. Reduction of hours of employment;
6. Employer contributions toward the group health plan were terminated for You or Your Dependents' coverage; or
7. A Child no longer qualifies for coverage as a Child under the other group health plan.
8. [9 In the event of a Group offering other Benefit Plan options to Medicare-eligible employees and/or retirees in addition to the Coverage provided under this Certificate, and a Medicare eligible employee and/or retiree enrolls in such benefit plan option, any individual who is otherwise eligible to enroll as the Subscriber's Dependent Spouse is eligible to enroll as the Subscriber for the purposes of this Certificate, subject to all of the terms and conditions of this Certificate, provided that the Dependent Spouse is not Medicare-eligible. Dependent children of the Subscriber's Dependent Spouse are also eligible to remain enrolled. Any Dependent Spouse enrolled as a Subscriber under this Certificate is still considered a Dependent spouse for the purposes of this Section (Who is Covered) and the Conversion Right to a New Contract After Termination and Continuation of Coverage Sections of the Certificate.]

You, Your Spouse or Child can also enroll 30 days from exhaustion of Your COBRA or continuation coverage or if You gain a Dependent or become a Dependent through marriage, birth, adoption, or placement for adoption.

We must receive notice and Premium payment within 30 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application. If You gain a Dependent or become a Dependent due to a birth, adoption, or placement for adoption, Your coverage will begin on the date of the birth, adoption or placement for adoption.

In addition, You, Your Spouse or Child, can also enroll for coverage within 60 days of the occurrence of one of the following events:

1. You or Your Spouse or Child loses eligibility for Medicaid or Child Health Plus; or
2. You or Your Spouse or Child becomes eligible for Medicaid or Child Health Plus.

We must receive notice and Premium payment within 60 days of one of these events. Your coverage will begin on the first day of the following month after We receive Your application.

SECTION VI

Preventive Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

Preventive Care.

We Cover the following services for the purpose of promoting good health and early detection of disease. Preventive services are not subject to Cost-Sharing (Copayments, Deductibles or Coinsurance) when performed by a Participating Provider and provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration (“HRSA”), or if the items or services have an “A” or “B” rating from the United States Preventive Services Task Force (“USPSTF”), or if the immunizations are recommended by the Advisory Committee on Immunization Practices (“ACIP”). However, Cost-Sharing may apply to services provided during the same visit as the preventive services. Also, if a preventive service is provided during an office visit wherein the preventive service is not the primary purpose of the visit, the Cost-Sharing amount that would otherwise apply to the office visit will still apply. You may contact Us at the number on Your ID card or visit Our website at www.cdphp.com for a copy of the comprehensive guidelines supported by HRSA, items or services with an “A” or “B” rating from USPSTF, and immunizations recommended by ACIP.

- A. Well-Baby and Well-Child Care.** We Cover well-baby and well-child care which consists of routine physical examinations including vision screenings and hearing screenings, developmental assessment, anticipatory guidance, and laboratory tests ordered at the time of the visit as recommended by the American Academy of Pediatrics. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. If the schedule of well-child visits referenced above permits one (1) well-child visit per Plan Year, We will not deny a well-child visit if 365 days have not passed since the previous well-child visit. Immunizations and boosters as recommended by ACIP are also Covered. This benefit is provided to Members from birth through attainment of age 19 and is not subject to Copayments, Deductibles or Coinsurance.
- B. Adult Annual Physical Examinations.** We Cover adult annual physical examinations and preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

Examples of items or services with an “A” or “B” rating from USPSTF include, but are not limited to, blood pressure screening for adults, lung cancer screening, colorectal cancer screening, alcohol misuse screening, depression screening,

and diabetes screening. A complete list of the Covered preventive Services is available on Our website at www.cdphp.com, or will be mailed to You upon request.

You are eligible for a physical examination once every Plan Year, regardless of whether or not 365 days have passed since the previous physical examination visit. Vision screenings do not include refractions.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

- C. Adult Immunizations.** We Cover adult immunizations as recommended by ACIP. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the recommendations of ACIP.
- D. Well-Woman Examinations.** We Cover well-woman examinations which consist of a routine gynecological examination, breast examination and annual screening for cervical cancer, including laboratory and diagnostic services in connection with evaluating cervical cancer screening tests. We also Cover preventive care and screenings as provided for in the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF. A complete list of the Covered preventive Services is available on Our website at www.cdphp.com, or will be mailed to You upon request. This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may be less frequent than described above.

E. Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer. We Cover mammograms, which may be provided by breast tomosynthesis (i.e., 3D mammograms), for the screening of breast cancer as follows:

- One (1) baseline screening mammogram for Members age 35 through 39;
- Upon the recommendation of the Member’s Provider, an annual screening mammogram for Members age 35 through 39 if Medically Necessary; and
- One (1) screening mammogram annually for Members age 40 and over.

If a Member of any age has a history of breast cancer or a first degree relative has a history of breast cancer, We Cover mammograms as recommended by the Member’s Provider. However, in no event will more than one (1) preventive screening per Plan Year be Covered.

Mammograms for the screening of breast cancer are not subject to Copayments, Deductibles or Coinsurance.

We also Cover additional screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs. Screening and diagnostic imaging for the detection of breast cancer, including diagnostic mammograms, breast ultrasounds and MRIs are not subject to Copayments, Deductibles or Coinsurance.

- F. Family Planning and Reproductive Health Services.** [10 We Cover family planning services which consist of: FDA-approved contraceptive methods prescribed by a Provider not otherwise Covered under the Prescription Drug Coverage section of this Certificate; patient education and counseling on use of contraceptives and related topics; follow-up services related to contraceptive methods, including management of side effects, counseling for continued adherence, and device insertion and removal; and sterilization procedures for women. Such services are not subject to Copayments, Deductibles or Coinsurance.

We also Cover vasectomies subject to Copayments, Deductibles or Coinsurance.

We do not Cover services related to the reversal of elective sterilizations.]

[11 Family planning and reproductive health services, such as contraceptive drugs and devices and sterilization procedures, are not Covered under the Certificate. You may purchase coverage for these services directly from Us.]

- G. Bone Mineral Density Measurements or Testing.** We Cover bone mineral density measurements or tests, and Prescription Drugs and devices approved by the FDA or generic equivalents as approved substitutes. Coverage of Prescription Drugs is subject to the Prescription Drug Coverage section of this Certificate. Bone mineral density measurements or tests, drugs or devices shall include those covered under the federal Medicare program or those in accordance with the criteria of the National Institutes of Health. You will qualify for Coverage if You meet the criteria under the federal Medicare program or the criteria of the National Institutes of Health or if You meet any of the following:

- Previously diagnosed as having osteoporosis or having a family history of osteoporosis;
- With symptoms or conditions indicative of the presence or significant risk of osteoporosis;
- On a prescribed drug regimen posing a significant risk of osteoporosis;
- With lifestyle factors to a degree as posing a significant risk of osteoporosis; or
- With such age, gender, and/or other physiological characteristics which pose a significant risk for osteoporosis.

We also Cover osteoporosis screening as provided for in the comprehensive

guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF.

This benefit is not subject to Copayments, Deductibles or Coinsurance when provided in accordance with the comprehensive guidelines supported by HRSA and items or services with an “A” or “B” rating from USPSTF, which may not include all of the above services such as drugs and devices.

H. Screening for Prostate Cancer. We Cover an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors. We also Cover standard diagnostic testing including, but not limited to, a digital rectal examination and a prostate-specific antigen test, at any age for men having a prior history of prostate cancer.

This benefit is not subject to Copayments, Deductibles or Coinsurance.

SECTION VII

Ambulance and Pre-Hospital Emergency Medical Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits. Pre-Hospital Emergency Medical Services and ambulance services for the treatment of an Emergency Condition do not require Preauthorization.

A. Emergency Ambulance Transportation.

1. Pre-Hospital Emergency Medical Services. We Cover Pre-Hospital Emergency Medical Services worldwide for the treatment of an Emergency Condition when such services are provided by an ambulance service.

“Pre-Hospital Emergency Medical Services” means the prompt evaluation and treatment of an Emergency Condition and/or non-airborne transportation to a Hospital. The services must be provided by an ambulance service issued a certificate under the New York Public Health Law. We will, however, only Cover transportation to a Hospital provided by such an ambulance service when a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of such transportation to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

An ambulance service must hold You harmless and may not charge or seek reimbursement from You for Pre-Hospital Emergency Medical Services except for the collection of any applicable Copayment, Deductible or Coinsurance

In the absence of negotiated rates, We will pay a Non-Participating Provider the usual and customary charge for Pre-Hospital Emergency Medical Services, which shall not be excessive or unreasonable. The usual and customary charge for Pre-Hospital Emergency Medical Services is the FAIR Health rate at the 80th percentile or the Provider’s billed charges.

2. Emergency Ambulance Transportation. In addition to Pre-Hospital Emergency Medical Services, We also Cover emergency ambulance transportation worldwide by a licensed ambulance service (either ground, water or air ambulance) to the nearest Hospital where Emergency Services can be performed. This coverage includes emergency ambulance transportation to a Hospital when the originating Facility does not have the ability to treat Your Emergency Condition.

B. Non-Emergency Ambulance Transportation.

We Cover non-emergency ambulance transportation by a licensed ambulance service (either ground or air ambulance, as appropriate) between Facilities when the transport is any of the following:

- From a non-participating Hospital to a participating Hospital;
- To a Hospital that provides a higher level of care that was not available at the original Hospital;
- To a more cost-effective Acute care Facility; or
- From an Acute care Facility to a sub-Acute setting.

C. Limitations/Terms of Coverage.

- We do not Cover travel or transportation expenses, unless connected to an Emergency Condition or due to a Facility transfer approved by Us, even though prescribed by a Physician.
- We do not Cover non-ambulance transportation such as ambulette, van or taxi cab.
- Coverage for air ambulance related to an Emergency Condition or air ambulance related to non-emergency transportation is provided when Your medical condition is such that transportation by land ambulance is not appropriate; and Your medical condition requires immediate and rapid ambulance transportation that cannot be provided by land ambulance; and one (1) of the following is met:
 - The point of pick-up is inaccessible by land vehicle; or
 - Great distances or other obstacles (e.g., heavy traffic) prevent Your timely transfer to the nearest Hospital with appropriate facilities.

SECTION VIII

Emergency Services and Urgent Care

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Emergency Services.

We Cover Emergency Services for the treatment of an Emergency Condition in a Hospital.

We define an “**Emergency Condition**” to mean: A medical or behavioral condition that manifests itself by Acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the person afflicted with such condition or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy;
- Serious impairment to such person’s bodily functions;
- Serious dysfunction of any bodily organ or part of such person; or
- Serious disfigurement of such person.

For example, an Emergency Condition may include, but is not limited to, the following conditions:

- Severe chest pain
- Severe or multiple injuries
- Severe shortness of breath
- Sudden change in mental status (e.g., disorientation)
- Severe bleeding
- Acute pain or conditions requiring immediate attention such as suspected heart attack or appendicitis
- Poisonings
- Convulsions

Coverage of Emergency Services for treatment of Your Emergency Condition will be provided regardless of whether the Provider is a Participating Provider. We will also Cover Emergency Services to treat Your Emergency Condition worldwide. However, We will Cover only those Emergency Services and supplies that are Medically Necessary and are performed to treat or stabilize Your Emergency Condition in a Hospital.

Please follow the instructions listed below regardless of whether or not You are in Our

Service Area at the time Your Emergency Condition occurs:

- 1. Hospital Emergency Department Visits.** In the event that You require treatment for an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. Emergency Department Care does not require Preauthorization. **However, only Emergency Services for the treatment of an Emergency Condition are Covered in an emergency department.**

We do not Cover follow-up care or routine care provided in a Hospital emergency department.

- 2. Emergency Hospital Admissions.** In the event that You are **admitted** to the Hospital, You or someone on Your behalf must notify Us at the number on Your ID card within 48 hours of Your admission, or as soon as is reasonably possible.

We Cover inpatient Hospital services following Emergency Department Care at a non-participating Hospital at the in-network Cost-Sharing. If Your medical condition permits Your transfer to a participating Hospital, We will notify You and arrange the transfer.

- 3. Payments Relating to Emergency Services Rendered.** The amount We pay a Non-Participating Provider for Emergency Services will be

the greater of: 1) the amount We have negotiated with Participating Providers for the Emergency Service (and if more than one amount is negotiated, the median of the amounts); 2) 100% of the Allowed Amount for services provided by a Non-Participating Provider (i.e., the amount We would pay in the absence of any Cost-Sharing that would otherwise apply for services of Non-Participating Providers); or 3) the amount that would be paid under Medicare. The amounts described above exclude any Copayment or Coinsurance that applies to Emergency Services provided by a Participating Provider.

If a dispute involving a payment for physician services is submitted to an independent dispute resolution entity ("IDRE"), We will pay the amount, if any, determined by the IDRE for physician services.

You are responsible for any Copayment, Deductible or Coinsurance. You will be held harmless for any Non-Participating Provider charges that exceed Your Copayment, Deductible or Coinsurance. Additionally, if You assign benefits to a Non-Participating Provider in writing, the Non-Participating Provider may only bill You for Your Copayment, Deductible or Coinsurance. If You receive a bill from a Non-Participating Provider that is more than Your Copayment, Deductible or Coinsurance, You should contact Us.

B. Urgent Care.

Urgent Care is medical care for an illness, injury or condition serious enough that a reasonable person would seek care right away, but not so severe as to require Emergency Department Care. Urgent Care is typically available after normal business hours, including evenings and weekends. If You need care after normal business hours, including evenings, weekends or holidays, You have options. You can call Your Provider's office for instructions or visit an Urgent Care Center. If You have an Emergency Condition, seek immediate care at the nearest Hospital emergency department or call 911. **Urgent Care is Covered in or out of Our Service Area.**

- 1. In-Network.** We Cover Urgent Care from a participating Physician or a participating Urgent Care Center. You do not need to contact Us prior to or after Your visit.
- 2. Out-of-Network.** We Cover Urgent Care from a non-participating Urgent Care Center outside Our Service Area. We are available 24 hours a day, seven (7) days a week to help You in urgent medical situations.

We do not Cover Urgent Care from non-participating Urgent Care Centers Our Service Area.

If Urgent Care results in an emergency admission, please follow the instructions for emergency Hospital admissions described above.

SECTION IX

Outpatient and Professional Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Acupuncture.

We Cover acupuncture services.

B. Advanced Imaging Services.

We Cover PET scans, MRI, nuclear medicine, and CAT scans.

C. Allergy Testing and Treatment.

We Cover testing and evaluations including injections, and scratch and prick tests to determine the existence of an allergy. We also Cover allergy treatment, including desensitization treatments, routine allergy injections and serums.

D. Ambulatory Surgical Center Services.

We Cover surgical procedures performed at Ambulatory Surgical Centers including services and supplies provided by the center the day the surgery is performed.

E. Chemotherapy and Immunotherapy.

We Cover chemotherapy and immunotherapy in an outpatient Facility or in a Health Care Professional's office. Chemotherapy and immunotherapy may be administered by injection or infusion. Orally-administered anti-cancer drugs are Covered under the Prescription Drug Coverage section of this Certificate.

F. Chiropractic Services.

We Cover chiropractic care when performed by a Doctor of Chiropractic ("chiropractor") in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of the vertebral column. This includes assessment, manipulation and any modalities. Any laboratory tests will be Covered in accordance with the terms and conditions of this Certificate.

G. Clinical Trials.

We Cover the routine patient costs for Your participation in an approved clinical trial and such coverage shall not be subject to Utilization Review if You are:

- Eligible to participate in an approved clinical trial to treat either cancer or other life-threatening disease or condition; and
- Referred by a Participating Provider who has concluded that Your participation in the approved clinical trial would be appropriate.

All other clinical trials, including when You do not have cancer or other life-threatening disease or condition, may be subject to the Utilization Review and External Appeal sections of this Certificate.

We do not Cover: the costs of the investigational drugs or devices; the costs of non-health services required for You to receive the treatment; the costs of managing the research; or costs that would not be covered under this Certificate for non-investigational treatments provided in the clinical trial.

An “approved clinical trial” means a phase I, II III, or IV clinical trial that is:

- A federally funded or approved trial;
- Conducted under an investigational drug application reviewed by the federal Food and Drug Administration; or
- A drug trial that is exempt from having to make an investigational new drug application.

H. Dialysis.

We Cover dialysis treatments of an Acute or chronic kidney ailment.

We also Cover dialysis treatments provided by a Non-Participating Provider subject to all the following conditions:

- The Non-Participating Provider is duly licensed to practice and authorized to provide such treatment.
- The Non-Participating Provider is located outside Our Service Area.
- The Participating Provider who is treating You has issued a written order indicating that dialysis treatment by the Non-Participating Provider is necessary.
- You notify Us in writing at least 30 days in advance of the proposed treatment date(s) and include the written order referred to above. The 30-day advance notice period may be shortened when You need to travel on sudden notice due to a family or other emergency, provided that We have a reasonable opportunity to review Your travel and treatment plans.
- We have the right to Preauthorize the dialysis treatment and schedule.
- Benefits for services of a Non-Participating Provider are Covered when all the above conditions are met and are subject to any applicable Cost-Sharing that applies to dialysis treatments by a Participating Provider. However, You are also responsible for paying any difference between the amount We would have paid had the service been provided by a Participating Provider and the Non-Participating Provider’s charge.

I. Home Health Care.

We Cover care provided in Your home by a Home Health Agency certified or licensed by the appropriate state agency. The care must be provided pursuant to Your Physician's written treatment plan and must be in lieu of Hospitalization or confinement in a Skilled Nursing Facility. Home care includes:

- Part-time or intermittent nursing care by or under the supervision of a registered professional nurse;
- Part-time or intermittent services of a home health aide;
- Physical, occupational or speech therapy provided by the Home Health Agency; and
- Medical supplies, Prescription Drugs and medications prescribed by a Physician, and laboratory services by or on behalf of the Home Health Agency to the extent such items would have been Covered during a Hospitalization or confinement in a Skilled Nursing Facility.

Each visit by a member of the Home Health Agency is considered one (1) visit. Each visit of up to four (4) hours by a home health aide is considered one (1) visit. Any Rehabilitation or Habilitation Services received under this benefit will not reduce the amount of services available under the Rehabilitation or Habilitation Services benefits.

J. Infertility Treatment.

We Cover services for the diagnosis and treatment (surgical and medical) of infertility. "Infertility" is a disease or condition characterized by the incapacity to impregnate another person or to conceive, defined by the failure to establish a clinical pregnancy after 12 months of regular, unprotected sexual intercourse or therapeutic donor insemination, or after six (6) months of regular, unprotected sexual intercourse or therapeutic donor insemination for a female 35 years of age or older. Earlier evaluation and treatment may be warranted based on a Member's medical history or physical findings.

Such Coverage is available as follows:

- 1. Basic Infertility Services.** Basic infertility services will be provided to a Member who is an appropriate candidate for infertility treatment. In order to determine eligibility, We will use guidelines established by the American College of Obstetricians and Gynecologists, the American Society for Reproductive Medicine, and the State of New York.

Basic infertility services include:

- Initial evaluation;
- Semen analysis;
- Laboratory evaluation;
- Evaluation of ovulatory function;
- Postcoital test;
- Endometrial biopsy;
- Pelvic ultra sound;
- Hysterosalpingogram;
- Sono-hystogram;
- Testis biopsy;
- Blood tests; and

- Medically appropriate treatment of ovulatory dysfunction.

Additional tests may be Covered if the tests are determined to be Medically Necessary.

2. Comprehensive Infertility Services. If the basic infertility services do not result in increased fertility, We Cover comprehensive infertility services.

Comprehensive infertility services include:

- Ovulation induction and monitoring;
- Pelvic ultra sound;
- Artificial insemination;
- Hysteroscopy;
- Laparoscopy; and
- Laparotomy.

3. Advanced Infertility Services. We Cover the following advanced infertility services:

- Three (3) cycles per lifetime of in vitro fertilization;
- Cryopreservation and storage of sperm, ova, and embryos in connection with in vitro fertilization.

A “cycle” is all treatment that starts when: preparatory medications are administered for ovarian stimulation for oocyte retrieval with the intent of undergoing in vitro fertilization using a fresh embryo transfer, or medications are administered for endometrial preparation with the intent of undergoing in vitro fertilization using a frozen embryo transfer.

4. Fertility Preservation Services. We Cover standard fertility preservation services when a medical treatment will directly or indirectly lead to iatrogenic infertility. Standard fertility preservation services include the collecting, preserving, and storing of ova and sperm. “Iatrogenic infertility” means an impairment of Your fertility by surgery, radiation, chemotherapy or other medical treatment affecting reproductive organs or processes.

5. Exclusions and Limitations. We do not Cover:

- Gamete intrafallopian tube transfers or zygote intrafallopian tube transfers;
- Costs associated with an ovum or sperm donor, including the donor’s medical expenses;
- Ovulation predictor kits;
- Reversal of tubal ligations;
- Reversal of vasectomies;
- Costs for and relating to surrogate motherhood (maternity services are Covered for Members acting as surrogate mothers);

- Cloning; or
- Medical and surgical procedures that are experimental or investigational, unless Our denial is overturned by an External Appeal Agent.

All services must be provided by Providers who are qualified to provide such services in accordance with the guidelines established and adopted by the American Society for Reproductive Medicine. We will not discriminate based on Your expected length of life, present or predicted disability, degree of medical dependency, perceived quality of life, other health conditions, or based on personal characteristics including age, sex, sexual orientation, marital status or gender identity, when determining coverage under this benefit.

K. Infusion Therapy.

We Cover infusion therapy which is the administration of drugs using specialized delivery systems. Drugs or nutrients administered directly into the veins are considered infusion therapy. Drugs taken by mouth or self-injected are not considered infusion therapy. The services must be ordered by a Physician or other authorized Health Care Professional and provided in an office or by an agency licensed or certified to provide infusion therapy.

[¹² L. Interruption of Pregnancy.

We Cover medically necessary abortions including abortions in cases of rape, incest or fetal malformation. We Cover elective abortions.]

M. Laboratory Procedures, Diagnostic Testing and Radiology Services.

We Cover x-ray, laboratory procedures and diagnostic testing, services and materials, including diagnostic x-rays, x-ray therapy, fluoroscopy, electrocardiograms, electroencephalograms, laboratory tests, and therapeutic radiology services.

N. Maternity and Newborn Care.

We Cover services for maternity care provided by a Physician or midwife, nurse practitioner, Hospital or birthing center. We Cover prenatal care (including one (1) visit for genetic testing), postnatal care, delivery, and complications of pregnancy. In order for services of a midwife to be Covered, the midwife must be licensed pursuant to Article 140 of the New York Education Law, practicing consistent with Section 6951 of the New York Education Law and affiliated or practicing in conjunction with a Facility licensed pursuant to Article 28 of the New York Public Health Law. We will not pay for duplicative routine services provided by both a midwife and a Physician. See the Inpatient Services section of this Certificate for Coverage of inpatient maternity care.

We Cover breastfeeding support, counseling and supplies, including the cost of renting or the purchase of one (1) breast pump per pregnancy or, if greater, one (1) per calendar year for the duration of breast feeding from a Participating Provider or designated vendor.

O. Office Visits.

We Cover office visits for the diagnosis and treatment of injury, disease and medical conditions. Office visits may include house calls.

[¹³ **Specialist e-Consultations Program.** If Your Participating Provider is in Our [¹⁴ Specialist e-Consultations Program] program and is rendering primary care services to You, he or she may request an electronic consultation with a Specialist to help evaluate Your condition or diagnosis. The electronic consultation will be provided by a Participating Provider who has agreed to participate in Our [¹⁵ Specialist e-Consultations Program] program and will be selected by Your Participating Provider in his or her clinical judgement. The electronic consultation will be at no cost to You. Your Participating Provider may consider the information provided by the Specialist in determining Your treatment. The consultation will be conducted using electronic information and communication technologies such as secure web-based email, fax and/or exchange of electronic medical records. The results may be documented in an electronic health record.]

P. Outpatient Hospital Services.

We Cover Hospital services and supplies as described in the Inpatient Services section of this Certificate that can be provided to You while being treated in an outpatient Facility. For example, Covered Services include but are not limited to inhalation therapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation.

Q. Preadmission Testing.

We Cover preadmission testing ordered by Your Physician and performed in Hospital outpatient Facilities prior to a scheduled surgery in the same Hospital provided that:

- The tests are necessary for and consistent with the diagnosis and treatment of the condition for which the surgery is to be performed;
- Reservations for a Hospital bed and operating room were made prior to the performance of the tests;
- Surgery takes place within seven (7) days of the tests; and
- The patient is physically present at the Hospital for the tests.

R. Prescription Drugs for Use in the Office and Outpatient Facilities.

We Cover Prescription Drugs (excluding self-injectable drugs) used by Your Provider in the Provider's office and Outpatient Facility for preventive and therapeutic purposes. This benefit applies when Your Provider orders the Prescription Drug and administers it to You. When Prescription Drugs are Covered under this benefit, they will not be Covered under the Prescription Drug Coverage section of this Certificate.

S. Retail Health Clinics.

We Cover basic health care services provided to You on a "walk-in" basis at retail health clinics, normally found in major pharmacies or retail stores. Covered Services are typically provided by a physician's assistant or nurse practitioner. Covered Services available at retail health clinics are limited to routine care and treatment of common

illnesses.

T. Rehabilitation Services.

We Cover Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy in the outpatient department of a Facility or in a Health Care Professional's office.

- Physical Therapy is limited to [16 30; 120] visits per Plan Year
- Occupational Therapy is limited to [17 30; 120] visits per Plan Year
- Speech Therapy is limited to [18 20; 60] visits per Plan Year

We Cover speech and physical therapy only when:

- Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
- The therapy is ordered by a Physician; or
- You have been hospitalized or have undergone surgery for such illness or injury.

U. Second Opinions.

- 1. Second Cancer Opinion.** We Cover a second medical opinion by an appropriate Specialist, including but not limited to a Specialist affiliated with a specialty care center, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer. You may obtain a second opinion from a Non-Participating Provider on an in-network basis.
- 2. Second Surgical Opinion.** We Cover a second surgical opinion by a qualified Physician on the need for surgery.
- 3. Required Second Surgical Opinion.** We may require a second opinion before We preauthorize a surgical procedure. There is no cost to You when We request a second opinion.
 - The second opinion must be given by a board certified Specialist who personally examines You.
 - If the first and second opinions do not agree, You may obtain a third opinion.
- 4. Second Opinions in Other Cases.** There may be other instances when You will disagree with a Provider's recommended course of treatment. In such cases, You may request that we designate another Provider to render a second opinion. If the first and second opinions do not agree, We will designate another Provider to render a third opinion. After completion of the second opinion process, We will approve Covered Services supported by a majority of the Providers reviewing Your case.

V. Surgical Services.

We Cover Physicians' services for surgical procedures, including operating and cutting procedures for the treatment of a sickness or injury, and closed reduction of fractures and dislocations of bones, endoscopies, incisions, or punctures of the skin on an inpatient and outpatient basis, including the services of the surgeon or Specialist, assistant (including a Physician's assistant or a nurse practitioner), and anesthetist or anesthesiologist, together with preoperative and post-operative care. Benefits are not available for anesthesia services provided as part of a surgical procedure when rendered by the surgeon or the surgeon's assistant.

Sometimes two (2) or more surgical procedures can be performed during the same operation.

- 1. Through the Same Incision.** If Covered multiple surgical procedures are performed through the same incision, We will pay for the procedure with the highest Allowed Amount.
- 2. Through Different Incisions.** If Covered multiple surgical procedures are performed during the same operative session but through different incisions, We will pay:
 - For the procedure with the highest Allowed Amount; and
 - 50% of the amount We would otherwise pay for the other procedures.

W. Oral Surgery.

We Cover the following limited dental and oral surgical procedures:

- Oral surgical procedures for jaw bones or surrounding tissue and dental services for the repair or replacement of sound natural teeth that are required due to accidental injury. Replacement is Covered only when repair is not possible. Dental services must be obtained within 12 months of the injury.
- Oral surgical procedures for jaw bones or surrounding tissue and dental services necessary due to congenital disease or anomaly.
- Oral surgical procedures required for the correction of a non-dental physiological condition which has resulted in a severe functional impairment.
- Removal of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth. Cysts related to teeth are not Covered.
- Surgical/nonsurgical medical procedures for temporomandibular joint disorders and orthognathic surgery.

X. Reconstructive Breast Surgery.

We Cover breast reconstruction surgery after a mastectomy or partial mastectomy. Coverage includes: all stages of reconstruction of the breast on which the mastectomy or partial mastectomy has been performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and physical complications of the mastectomy or partial mastectomy, including lymphedemas, in a manner determined by You and Your attending Physician to be appropriate. We also Cover implanted breast prostheses following a mastectomy or partial mastectomy.

Y. Other Reconstructive and Corrective Surgery.

We Cover reconstructive and corrective surgery other than reconstructive breast surgery only when it is:

- Performed to correct a congenital birth defect of a covered Child which has resulted in a functional defect;
- Incidental to surgery or follows surgery that was necessitated by trauma, infection or disease of the involved part; or
- Otherwise Medically Necessary.

Z. Telemedicine Program.

In addition to providing Covered Services via telehealth, We Cover online internet consultations between You and Providers who participate in Our telemedicine program for medical conditions that are not an Emergency Condition. Not all Participating Providers participate in Our telemedicine program. You can check Our Provider directory or contact Us for a listing of the Providers that participate in Our telemedicine program.

Our telemedicine program allows members to communicate with Providers through two-way video and can be easily accessed through our Member site at www.cdphp.com.

AA. Transplants.

We Cover only those transplants determined to be non-experimental and non-investigational. Covered transplants include but are not limited to: kidney, corneal, liver, heart, pancreas and lung transplants and bone marrow transplants for aplastic anemia, leukemia, severe combined immunodeficiency disease and Wiskott-Aldrich Syndrome.

All transplants must be prescribed by Your Specialist(s). Additionally, all transplants must be performed at Hospitals that We have specifically approved and designated to perform these procedures.

We Cover the Hospital and medical expenses, including donor search fees, of the Member-recipient. We Cover transplant services required by You when You serve as an organ donor only if the recipient is a Member. We do not Cover the medical expenses of a non-Member acting as a donor for You if the non-Member's expenses will be Covered under another health plan or program.

We do not Cover: travel expenses, lodging, meals, or other accommodations for donors or guests; donor fees in connection with organ transplant surgery; or routine harvesting and storage of stem cells from newborn cord blood.

SECTION X

Additional Benefits, Equipment and Devices

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Autism Spectrum Disorder.

We Cover the following services when such services are prescribed or ordered by a licensed Physician or a licensed psychologist and are determined by Us to be Medically Necessary for the screening, diagnosis, and treatment of autism spectrum disorder. For purposes of this benefit, "autism spectrum disorder" means any pervasive developmental disorder defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders at the time services are rendered.

- 1. Screening and Diagnosis.** We Cover assessments, evaluations, and tests to determine whether someone has autism spectrum disorder.
- 2. Assistive Communication Devices.** We Cover a formal evaluation by a speech-language pathologist to determine the need for an assistive communication device. Based on the formal evaluation, We Cover the rental or purchase of assistive communication devices when ordered or prescribed by a licensed Physician or a licensed psychologist if You are unable to communicate through normal means (i.e., speech or writing) when the evaluation indicates that an assistive communication device is likely to provide You with improved communication. Examples of assistive communication devices include communication boards and speech-generating devices. Coverage is limited to dedicated devices. We will only Cover devices that generally are not useful to a person in the absence of a communication impairment. We do not Cover items, such as, but not limited to, laptop, desktop or tablet computers. We Cover software and/or applications that enable a laptop, desktop or tablet computer to function as a speech-generating device. Installation of the program and/or technical support is not separately reimbursable. We will determine whether the device should be purchased or rented.

We Cover repair, replacement fitting and adjustments of such devices when made necessary by normal wear and tear or significant change in Your physical condition. We do not Cover the cost of repair or replacement made necessary because of loss or damage caused by misuse, mistreatment, or theft; however, We Cover one (1) repair or replacement per device type that is necessary due to behavioral issues. Coverage will be provided for the device most appropriate to Your current functional level. We do not Cover delivery or service charges or routine maintenance.

- 3. Behavioral Health Treatment.** We Cover counseling and treatment programs that are necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual. We will provide such Coverage when provided by a licensed Provider. We Cover applied behavior analysis when provided by a licensed or certified applied behavior analysis Health Care Professional. "Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior. The treatment program must describe measurable goals that address the condition and functional impairments for which the intervention is to be applied and include goals from an initial assessment and subsequent interim assessments over the duration of the intervention in objective and measurable terms.
- 4. Psychiatric and Psychological Care.** We Cover direct or consultative services provided by a psychiatrist, psychologist or a licensed clinical social worker with the experience required by the New York Insurance Law, licensed in the state in which they are practicing.
- 5. Therapeutic Care.** We Cover therapeutic services necessary to develop, maintain, or restore, to the greatest extent practicable, functioning of the individual when such services are provided by licensed or certified speech therapists, occupational therapists, physical therapists and social workers to treat autism spectrum disorder and when the services provided by such Providers are otherwise Covered under this Certificate. Except as otherwise prohibited by law, services provided under this paragraph shall be included in any visit maximums applicable to services of such therapists or social workers under this Certificate.
- 6. Pharmacy Care.** We Cover Prescription Drugs to treat autism spectrum disorder that are prescribed by a Provider legally authorized to prescribe under Title 8 of the New York Education Law. Coverage of such Prescription Drugs is subject to all the terms, provisions, and limitations that apply to Prescription Drug benefits under this Certificate.
- 7. Limitations.** We do not Cover any services or treatment set forth above when such services or treatment are provided pursuant to an individualized education plan under the New York Education Law. The provision of services pursuant to an individualized family service plan under Section 2545 of the New York Public Health Law, an individualized education plan under Article 89 of the New York Education Law, or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities shall not affect coverage under this Certificate for services provided on a supplemental basis outside of an educational setting if such services are prescribed by a licensed Physician or licensed psychologist.

You are responsible for any applicable Copayment, Deductible or Coinsurance provisions under this Certificate for similar services. For example, any Copayment, Deductible or Coinsurance that applies to physical therapy visits will generally also apply to physical therapy services Covered under this benefit; and any Copayment, Deductible or Coinsurance for Prescription Drugs will generally also apply to Prescription Drugs Covered under this benefit. See the Schedule of Benefits section of this Certificate for the Cost-Sharing requirements that apply to applied behavior analysis services and assistive communication devices.

Nothing in this Certificate shall be construed to affect any obligation to provide coverage for otherwise-Covered Services solely on the basis that the services constitute early intervention program services pursuant to Section 3235-a of the New York Insurance Law or an individualized service plan pursuant to regulations of the New York State Office for People With Developmental Disabilities.

B. Diabetic Equipment, Supplies and Self-Management Education.

We Cover diabetic equipment, supplies, and self-management education if recommended or prescribed by a Physician or other licensed Health Care Professional legally authorized to prescribe under Title 8 of the New York Education Law as described below:

1. Equipment and Supplies.

We Cover the following equipment and related supplies for the treatment of diabetes when prescribed by Your Physician or other Provider legally authorized to prescribe:

- Acetone reagent strips
- Acetone reagent tablets
- Alcohol or peroxide by the pint
- Alcohol wipes
- All insulin preparations
- Automatic blood lance kit
- Cartridges for the visually impaired
- Diabetes data management systems
- Disposable insulin and pen cartridges
- Drawing-up devices for the visually impaired
- Equipment for use of the pump
- Glucagon for injection to increase blood glucose concentration
- Glucose acetone reagent strips
- Glucose kit
- Glucose monitor with or without special features for visually impaired, control solutions, and strips for home blood glucose monitor
- Glucose reagent tape
- Glucose test or reagent strips

- Injection aides
- Injector (Busher) Automatic
- Insulin
- Insulin cartridge delivery
- Insulin infusion devices
- Insulin pump
- Lancets
- Oral agents such as glucose tablets and gels
- Oral anti-diabetic agents used to reduce blood sugar levels
- Syringe with needle; sterile 1 cc box
- Urine testing products for glucose and ketones
- Additional supplies, as the New York State Commissioner of Health shall designate by regulation as appropriate for the treatment of diabetes.

Diabetic equipment and supplies are Covered only when obtained from a designated diabetic equipment or supply manufacturer which has an agreement with Us to provide all diabetic equipment or supplies required by law for Members through participating pharmacies. If You require a certain item not available from Our designated diabetic equipment or supply manufacturer, You or Your Provider must submit a request for a medical exception by calling the number on Your ID card. Our medical director will make all medical exception determinations.

2. Self-Management Education.

Diabetes self-management education is designed to educate persons with diabetes as to the proper self-management and treatment of their diabetic condition, including information on proper diets. We Cover education on self-management and nutrition when: diabetes is initially diagnosed; a Physician diagnoses a significant change in Your symptoms or condition which necessitates a change in Your self-management education; or when a refresher course is necessary. It must be provided in accordance with the following:

- By a Physician, other health care Provider authorized to prescribe under Title 8 of the New York Education Law, or their staff during an office visit;
- Upon the Referral of Your Physician or other health care Provider authorized to prescribe under Title 8 of the New York Education Law to the following non-Physician, medical educators: certified diabetes nurse educators; certified nutritionists; certified dietitians; and registered dietitians in a group setting when practicable; and
- Education will also be provided in Your home when Medically Necessary.

3. Limitations.

The items will only be provided in amounts that are in accordance with the treatment plan developed by the Physician for You. We Cover only basic models of blood glucose monitors unless You have special needs relating to poor vision or blindness or as otherwise Medically Necessary.

C. Durable Medical Equipment and Braces.

We Cover the rental or purchase of durable medical equipment and braces.

1. Durable Medical Equipment.

Durable Medical Equipment is equipment which is:

- Designed and intended for repeated use;
- Primarily and customarily used to serve a medical purpose;
- Generally not useful to a person in the absence of disease or injury; and
- Appropriate for use in the home.

Coverage is for standard equipment only. We Cover the cost of repair or replacement when made necessary by normal wear and tear. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You. We will determine whether to rent or purchase such equipment. We do not Cover over-the-counter durable medical equipment.

We do not Cover equipment designed for Your comfort or convenience (e.g., pools, hot tubs, air conditioners, saunas, humidifiers, dehumidifiers, exercise equipment), as it does not meet the definition of durable medical equipment.

2. Braces.

We Cover braces, including orthotic braces, that are worn externally and that temporarily or permanently assist all or part of an external body part function that has been lost or damaged because of an injury, disease or defect. Coverage is for standard equipment only. We Cover replacements when growth or a change in Your medical condition make replacement necessary. We do not Cover the cost of repair or replacement that is the result of misuse or abuse by You.

D. Hearing Aids.

1. External Hearing Aids.

We Cover hearing aids required for the correction of a hearing impairment (a reduction in the ability to perceive sound which may range from slight to complete deafness). Hearing aids are electronic amplifying devices designed to bring sound more effectively into the ear. A hearing aid consists of a microphone, amplifier and receiver.

Covered Services are available for a hearing aid that is purchased as a result of a written recommendation by a Physician and include the hearing aid and the charges for associated fitting and testing. We Cover a single purchase (including repair and/or replacement) of hearing aids for one (1) or both ears [¹⁹ once every three (3) years].

2. Cochlear Implants.

We Cover bone anchored hearing aids (i.e., cochlear implants) when they are

Medically Necessary to correct a hearing impairment. Examples of when bone anchored hearing aids are Medically Necessary include the following:

- Craniofacial anomalies whose abnormal or absent ear canals preclude the use of a wearable hearing aid; or
- Hearing loss of sufficient severity that it would not be adequately remedied by a wearable hearing aid.

Coverage is provided for one (1) hearing aid per ear during the entire period of time that You are enrolled under this Certificate. We Cover repair and/or replacement of a bone anchored hearing aid only for malfunctions.

E. Hospice.

Hospice Care is available if Your primary attending Physician has certified that You have six (6) months or less to live. We Cover inpatient Hospice Care in a Hospital or hospice and home care and outpatient services provided by the hospice, including drugs and medical supplies. Coverage is provided for 210 days of Hospice Care. We also Cover five (5) visits for supportive care and guidance for the purpose of helping You and Your immediate family cope with the emotional and social issues related to Your death, either before or after Your death.

We Cover Hospice Care only when provided as part of a Hospice Care program certified pursuant to Article 40 of the New York Public Health Law. If care is provided outside New York State, the hospice must be certified under a similar certification process required by the state in which the hospice is located. We do not Cover: funeral arrangements; pastoral, financial, or legal counseling; or homemaker, caretaker, or respite care.

F. Medical Supplies.

We Cover medical supplies that are required for the treatment of a disease or injury which is Covered under this Certificate. We also Cover maintenance supplies (e.g., ostomy supplies) for conditions Covered under this Certificate. All such supplies must be in the appropriate amount for the treatment or maintenance program in progress. We do not Cover over-the-counter medical supplies. See the Diabetic Equipment, Supplies, and Self-Management Education section above for a description of diabetic supply Coverage.

G. Prosthetics.

1. External Prosthetic Devices.

We Cover prosthetic devices (including wigs) that are worn externally and that temporarily or permanently replace all or part of an external body part that has been lost or damaged because of an injury or disease. We Cover wigs only when You have severe hair loss due to injury or disease or as a side effect of the treatment of a disease (e.g., chemotherapy). We do not Cover wigs made from human hair unless You are allergic to all synthetic wig materials.

We do not Cover dentures or other devices used in connection with the teeth unless required due to an accidental injury to sound natural teeth or necessary due to congenital disease or anomaly.

Eyeglasses and contact lenses are not Covered.

We do not Cover shoe inserts.

We Cover external breast prostheses following a mastectomy, which are not subject to any lifetime limit.

Coverage is for standard equipment only.

We Cover the cost of prosthetic devices. We Cover the cost of repair and replacement of the prosthetic devices and their parts. We do not Cover the cost of repair or replacement covered under warranty or if the repair or replacement is the result of misuse or abuse by You.

2. Internal Prosthetic Devices.

We Cover surgically implanted prosthetic devices and special appliances if they improve or restore the function of an internal body part which has been removed or damaged due to disease or injury. This includes implanted breast prostheses following a mastectomy or partial mastectomy in a manner determined by You and Your attending Physician to be appropriate.

Coverage also includes repair and replacement due to normal growth or normal wear and tear.

Coverage is for standard equipment only.

SECTION XI

Inpatient Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Hospital Services.

We Cover inpatient Hospital services for Acute care or treatment given or ordered by a Health Care Professional for an illness, injury or disease of a severity that must be treated on an inpatient basis, including:

- Semiprivate room and board;
- General, special and critical nursing care;
- Meals and special diets;
- The use of operating, recovery and cystoscopic rooms and equipment;
- The use of intensive care, special care or cardiac care units and equipment;
- Diagnostic and therapeutic items, such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes and administration, but not including those which are not commercially available for purchase and readily obtainable by the Hospital;
- Dressings and casts;
- Supplies and the use of equipment in connection with oxygen, anesthesia, physiotherapy, chemotherapy, electrocardiographs, electroencephalographs, x-ray examinations and radiation therapy, laboratory and pathological examinations;
- Blood and blood products except when participation in a volunteer blood replacement program is available to You;
- Radiation therapy, inhalation therapy, chemotherapy, pulmonary rehabilitation, infusion therapy and cardiac rehabilitation;
- Short-term physical, speech and occupational therapy; and
- Any additional medical services and supplies which are provided while You are a registered bed patient and which are billed by the Hospital.

The Cost-Sharing requirements in the Schedule of Benefits section of this Certificate apply to a continuous Hospital confinement, which is consecutive days of in-Hospital service received as an inpatient or successive confinements when discharge from and readmission to the Hospital occur within a period of not more than 90 days for the same or related causes.

B. Observation Services.

We Cover observation services in a Hospital. Observation services are Hospital outpatient services provided to help a Physician decide whether to admit or discharge

You. These services include use of a bed and periodic monitoring by nursing or other licensed staff.

C. Inpatient Medical Services.

We Cover medical visits by a Health Care Professional on any day of inpatient care Covered under this Certificate.

D. Inpatient Stay for Maternity Care.

We Cover inpatient maternity care in a Hospital for the mother, and inpatient newborn care in a Hospital for the infant, for at least 48 hours following a normal delivery and at least 96 hours following a caesarean section delivery, regardless of whether such care is Medically Necessary. The care provided shall include parent education, assistance, and training in breast or bottle-feeding, and the performance of any necessary maternal and newborn clinical assessments. We will also Cover any additional days of such care that We determine are Medically Necessary. In the event the mother elects to leave the Hospital and requests a home care visit before the end of the 48-hour or 96-hour minimum Coverage period, We will Cover a home care visit. The home care visit will be provided within 24 hours after the mother's discharge, or at the time of the mother's request, whichever is later. Our Coverage of this home care visit shall be in addition to home health care visits under this Certificate and shall not be subject to any Cost-Sharing amounts in the Schedule of Benefits section of this Certificate that apply to home care benefits.

We also Cover the inpatient use of pasteurized donor human milk, which may include fortifiers as Medically Necessary, for which a Health Care Professional has issued an order for an infant who is medically or physically unable to receive maternal breast milk, participate in breast feeding, or whose mother is medically or physically unable to produce maternal breast milk at all or in sufficient quantities or participate in breast feeding despite optimal lactation support. Such infant must have a documented birth weight of less than one thousand five hundred grams, or a congenital or acquired condition that places the infant at a high risk for development of necrotizing enterocolitis.

E. Inpatient Stay for Mastectomy Care.

We Cover inpatient services for Members undergoing a lymph node dissection, lumpectomy, mastectomy or partial mastectomy for the treatment of breast cancer and any physical complications arising from the mastectomy, including lymphedema, for a period of time determined to be medically appropriate by You and Your attending Physician.

F. Autologous Blood Banking Services.

We Cover autologous blood banking services only when they are being provided in connection with a scheduled, Covered inpatient procedure for the treatment of a disease or injury. In such instances, We Cover storage fees for a reasonable storage period that is appropriate for having the blood available when it is needed.

G. Rehabilitation Services.

We Cover inpatient Rehabilitation Services consisting of physical therapy, speech therapy and occupational therapy for 60 days per Plan Year. The visit limit applies to all therapies combined.

We Cover speech and physical therapy only when:

1. Such therapy is related to the treatment or diagnosis of Your illness or injury (in the case of a covered Child, this includes a medically diagnosed congenital defect);
2. The therapy is ordered by a Physician; or
3. You have been hospitalized or have undergone surgery for such illness or injury.

Covered Rehabilitation Services must begin within six (6) months of the later to occur:

1. The date of the injury or illness that caused the need for the therapy;
2. The date You are discharged from a Hospital where surgical treatment was rendered; or
3. The date outpatient surgical care is rendered.

H. Skilled Nursing Facility.

We Cover services provided in a Skilled Nursing Facility, including care and treatment in a semi-private room, as described in "Hospital Services" above. Custodial, convalescent or domiciliary care is not Covered (see the Exclusions and Limitations section of this Certificate). An admission to a Skilled Nursing Facility must be supported by a treatment plan prepared by Your Provider and approved by Us. We Cover up to [20 45; 90] days per Plan Year for non-custodial care.

I. End of Life Care.

If You are diagnosed with advanced cancer and You have fewer than 60 days to live, We will Cover Acute care provided in a licensed Article 28 Facility or Acute care Facility that specializes in the care of terminally ill patients. Your attending Physician and the Facility's medical director must agree that Your care will be appropriately provided at the Facility. If We disagree with Your admission to the Facility, We have the right to initiate an expedited external appeal to an External Appeal Agent. We will Cover and reimburse the Facility for Your care, subject to any applicable limitations in this Certificate until the External Appeal Agent renders a decision in Our favor.

We will reimburse Non-Participating Providers for this end of life care as follows:

1. We will reimburse a rate that has been negotiated between Us and the Provider.
2. If there is no negotiated rate, We will reimburse Acute care at the Facility's current Medicare Acute care rate.
3. If it is an alternate level of care, We will reimburse at 75% of the appropriate Medicare Acute care rate.

J. Limitations/Terms of Coverage.

1. When You are receiving inpatient care in a Facility, We will not Cover additional charges for special duty nurses, charges for private rooms (unless a private room is Medically Necessary), or medications and supplies You take home from the Facility. If You occupy a private room, and the private room is not Medically Necessary, Our Coverage will be based on the Facility's maximum semi-private room charge. You will have to pay the difference between that charge and the private room charge.
2. We do not Cover radio, telephone or television expenses, or beauty or barber services.
3. We do not Cover any charges incurred after the day We advise You it is no longer Medically Necessary for You to receive inpatient care, unless Our denial is overturned by an External Appeal Agent.

SECTION XII

Mental Health Care and Substance Use Services

Please refer to the Schedule of Benefits section of this Certificate for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits which are no more restrictive than those that apply to medical and surgical benefits in accordance with the federal Mental Health Parity and Addiction Equity Act of 2008.

A. Mental Health Care Services. We Cover the following mental health care services to treat a mental health condition. For purposes of this benefit, “mental health condition” means any mental health disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

1. Inpatient Services. We Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions comparable to other similar Hospital, medical and surgical coverage provided under Certificate. Coverage for inpatient services for mental health care is limited to Facilities defined in New York Mental Hygiene Law Section 1.03(10), such as:

- A psychiatric center or inpatient Facility under the jurisdiction of the New York State Office of Mental Health;
- A state or local government run psychiatric inpatient Facility;
- A part of a Hospital providing inpatient mental health care services under an operating certificate issued by the New York State Commissioner of Mental Health;
- A comprehensive psychiatric emergency program or other Facility providing inpatient mental health care that has been issued an operating certificate by the New York State Commissioner of Mental Health;

and, in other states, to similarly licensed or certified Facilities. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

We also Cover inpatient mental health care services relating to the diagnosis and treatment of mental health conditions received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities defined in New York Mental Hygiene Law Section 1.03 and to residential treatment facilities that are part of a comprehensive care center for eating disorders identified pursuant to New York Mental Hygiene Law Article 30; and, in other states, to Facilities that are licensed or certified to provide the same level of treatment. In the absence of a licensed or certified Facility that provides the same level of treatment, the Facility must be accredited by the Joint Commission on Accreditation of Health Care

Organizations or a national accreditation organization recognized by Us.

- 2. Outpatient Services.** We Cover outpatient mental health care services, including but not limited to partial hospitalization program services and intensive outpatient program services, relating to the diagnosis and treatment of mental health conditions. Coverage for outpatient services for mental health care includes Facilities that have been issued an operating certificate pursuant to New York Mental Hygiene Law Article 31 or are operated by the New York State Office of Mental Health and, in other states, to similarly licensed or certified Facilities; and services provided by a licensed psychiatrist or psychologist; a licensed clinical social worker who has at least three (3) years of additional experience in psychotherapy; a licensed nurse practitioner; a licensed mental health counselor; or a professional corporation or a university faculty practice corporation thereof. In the absence of a similarly licensed or certified Facility, the Facility must be accredited by the Joint Commission on Accreditation of Health Care Organizations or a national accreditation organization recognized by Us.

B. Substance Use Services. We Cover the following substance use services to treat a substance use disorder. For purposes of this benefit, “substance use disorder” means any substance use disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders.

- 1. Inpatient Services.** We Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders. This includes Coverage for detoxification and rehabilitation services for substance use disorders. Inpatient substance use services are limited to Facilities in New York State which are licensed, certified or otherwise authorized by the Office of Addiction Services and Supports (“OASAS”); and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission as alcoholism, substance abuse or chemical dependence treatment programs.

We also Cover inpatient substance use services relating to the diagnosis and treatment of substance use disorders received at Facilities that provide residential treatment, including room and board charges. Coverage for residential treatment services is limited to Facilities that are licensed, certified or otherwise authorized by OASAS; and, in other states, to those Facilities that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs to provide the same level of treatment.

- 2. Outpatient Services.** We Cover outpatient substance use services relating to the diagnosis and treatment of substance use disorders, including but not limited to partial hospitalization program services, intensive outpatient program services,

opioid treatment programs including peer support services, counseling, and medication-assisted treatment. Such Coverage is limited to Facilities in New York State that are licensed, certified or otherwise authorized by OASAS to provide outpatient substance use disorder services and, in other states, to those that are licensed, certified or otherwise authorized by a similar state agency and accredited by the Joint Commission or a national accreditation organization recognized by Us as alcoholism, substance abuse or chemical dependence treatment programs. Coverage in an OASAS-certified Facility includes services relating to the diagnosis and treatment of a substance use disorder provided by an OASAS credentialed Provider. Coverage is also available in a professional office setting for outpatient substance use disorder services relating to the diagnosis and treatment of alcoholism, substance use and dependency or by Physicians who have been granted a waiver pursuant to the federal Drug Addiction Treatment Act of 2000 to prescribe Schedule III, IV and V narcotic medications for the treatment of opioid addiction during the Acute detoxification stage of treatment or during stages of rehabilitation.

Additional Family Counseling. We also Cover up to 20 outpatient visits per Plan Year for family counseling. A family member will be deemed to be covered, for the purposes of this provision, so long as that family member: 1) identifies himself or herself as a family member of a person suffering from a substance use disorder; and 2) is covered under the same family Certificate that covers the person receiving, or in need of, treatment for a substance use disorder. Our payment for a family member therapy session will be the same amount, regardless of the number of family members who attend the family therapy session.

SECTION XIII

Wellness Benefits

A. Exercise Program Reimbursement.

We will partially reimburse the Subscriber and their covered Dependents for certain exercise facility or membership fees, exercise classes (e.g., yoga, pilates, spinning) or specified digital fitness programs but only if such fees are paid for programs that promote cardiovascular wellness.

Memberships in tennis clubs, country clubs, weight loss clinics, spas or any other similar facilities will not be reimbursed. Lifetime memberships are not eligible for reimbursement. We will not provide reimbursement for equipment, clothing, vitamins or other services that may be offered by the facility or digital platform (e.g., massages, etc.).

In order to be eligible for reimbursement, You must:

- Be an active member of the exercise facility, attend classes at the exercise facility or paid for a digital fitness program; and
- Complete 50 visits or workout sessions.

In order to obtain reimbursement, once 50 visits or workout sessions have been completed, You must submit:

- A completed reimbursement form.
- A copy of Your current bill which shows the fee paid for Your membership, classes or digital fitness program.

Once We receive the completed reimbursement form and the bill, You will be reimbursed the lesser of \$200 for the Subscriber and \$100 for their covered Dependents or the actual cost of the membership, class or digital fitness program. Eligible members can submit for reimbursement after completing 50 visits or workout sessions, up to two times during the Plan Year. Total combined maximum reimbursement for the Subscriber and their Dependents is \$600 per Plan Year.

[²¹ 2. Youth Fitness Program].

We will reimburse You for a trial membership with a [²² preferred; participating; designated] fitness center when a Covered, eligible Dependent Child completes a designed fitness and exercise program. The program provides eligible Dependent Child with fun and effective exercises that build healthy muscles, bones, and joints. Participants will become comfortable and confident about exercise with guidance from a certified fitness specialist. Participants receive a fitness assessment at both the beginning and end of the program, an individualized exercise plan, and instruction on techniques and exercises for a healthy lifestyle.

Participation requirements for the program, Preauthorization requirements and descriptions of activities available can be easily accessed through Our Member site at www.cdphp.com or by calling Our member services department at the number on Your ID card.

[²³ 3. Medical Condition Fitness Program].

[Medical Condition Fitness Program] is a collection of fitness programs for individuals transitioning from or managing a medical condition or needing additional support to improve their level of physical activity. These programs offer specific support in the following areas: Cancer Fitness, Cardiac Fitness, Diabetes Fitness, Fit for Surgery, Functional Fitness, Orthopedic Fitness, Pulmonary Fitness, Transitional Care, Weight Management, Behavioral Health. Each program includes health assessments at the beginning and end of the program, an Individualized exercise plan, supervised group workout sessions and a program summary report available to You and Your referring healthcare provider.

Participation requirements for the program, Preauthorization requirements and descriptions of activities available can be easily accessed through Our Member site at www.cdphp.com or by calling Our member services department at the number on Your ID card.]

B. Wellness Program.

[²⁴ 1. Wellness Program Name].

Purpose.

The purpose of this wellness program is to encourage You to take a more active role in managing Your health and well-being.

Description.

This program encourages You to participate in a variety of health and wellness programs designed to help You better manage Your health, while providing You incentives to be proactive and live a healthier, happier, and more productive life. Participation in the program as well as more information can be easily accessed through Our Member site at www.cdphp.com.

Rewards:

Participants are eligible to receive points per contract, per calendar year for completion of various programs and activities focused on improving health and wellness of the member. Activities for which points can be earned include:

Completion of an annual physical exam, completion of personal health assessment, and participation in cancer screenings. Descriptions of the activities available for completion in the program are available on Our member site at www.cdphp.com.

Each point translates into one dollar and can be redeemed for gift cards from a variety of retailers. CDPHP encourages members to continue making positive healthy choices by using gift cards for products or services that promote a healthy lifestyle.

Program guidelines:

The program is available to subscribers that are 18 and older. Points earned under this program are automatically reported through claims or are self-reported by the member. Members can self report activities, track activity completion and points earned, and redeem gift cards through Our website at www.cdphp.com or by calling Our member services department at the number on their ID card.

The eligibility period of the program is on a calendar year basis. All activities must be complete and points must be earned and redeemed within the calendar year or prior to termination of Your coverage. Any points not redeemed by the last day of the calendar year or prior to termination of Your coverage will be forfeited.

Accommodations:

If a member is unable to participate in this program due to a medical condition, CDPHP will work with the member to develop alternative offerings.

[²⁵ 2. Condition Specific Health and Wellness Program].**Purpose.**

We offer a variety of condition specific health and wellness program is to encourage You to take a more active role in managing Your health condition and improve Your quality of life.

Description.

The goal of these programs is to provide You with the tools and incentives to help You successfully manage Your health condition. Adhering to a lifestyle plan and adapting healthy habits, can help keep Your condition under control, significantly reduce the occurrence of long-term health complications and lower Your health care costs. Guided and self-management education programs and coordination of care can help You learn skills to manage symptoms of Your condition, improve eating and sleeping habits, reduce stress, maintain a healthy lifestyle, and more. Our programs offer a tailored experience, designed to fit your individual lifestyle and personal health goals. Education resources and materials will help You learn to recognize triggers and early symptoms, Identify risk factors and create and follow a treatment or management plan. In addition to education and support, Our programs also provide You with tools for success, which may include: supplies associated with managing Your condition, phone-based app services and associated software, personalized coaching from trained health coaches and/or care teams, self-guided online lessons, help monitoring and tracking and evaluating Your condition and medication adherence. Participation information for Our programs, as well as Preauthorization requirements

and descriptions of activities available, can be easily accessed through Our member site at www.cdphp.com or by calling Our member services department at the number on Your ID card.

Eligibility.

You, the Subscriber, and each covered Dependent can participate in the wellness program as long as You meet the eligibility criteria for that specific program. Some programs are limited to those Members with a specific diagnosis (e.g. asthma or diabetes). To see the specific eligibility criteria for Our Programs, please see the Program descriptions available through our member site at www.cdphp.com.

The eligibility period for Our programs, can be found under the specific program descriptions on Our member website at www.cdphp.com. We reserve the right at any time to alter or stop providing a specific Program. In such case We will notify You or Your representative in writing.

Accommodations:

If a member is unable to participate in a program, for which they are otherwise eligible, due to a medical condition, CDPHP will work with the member to develop alternative offerings

Participation.

The preferred method for accessing the wellness program is through Our website at www.cdphp.com. You need to have access to a computer with internet access in order to participate in the website program. However, if You do not have access to a computer, please call Us at the number on Your ID card and We will provide You with information regarding how to participate without internet access.

Rewards.

Rewards for participation in Our programs may include:

- Full or partial reimbursement of the cost of participating in the programs (e.g. membership fee waiver for smart phone access).
- Full or partial reimbursement of the cost of services related to the program (e.g. discounted fitness trainer services for those recovering from a recent hip replacement).
- The waiver or reduction of Copayments, Deductibles or Coinsurance.
- Monetary rewards in the form of cash, gift cards or gift certificates, so long as the recipient is encouraged to use the reward for a product or service that promotes good health, such as healthy cook books, over-the-counter vitamins or exercise equipment.
- Merchandise, so long as the item is geared at promoting good health, such as healthy cookbooks or nutritional or exercise equipment.
- See specific details of the rewards available under each program at www.cdphp.com.

[²⁶ 3. Maternity and Family Health Wellness Program].

We will partially reimburse eligible Members for participating in Our [Maternity and Family Health Wellness Program]. [Maternity and Family Health Wellness Program] provides Members with health and wellness education and support necessary to enrich their experience with family planning, pregnancy and the postpartum period, as well as, child-rearing years. Programs include education and resources, as well as lifestyle benefits, to support Members. Participation and preauthorization requirements for the program(s), as well as descriptions of activities available, can be easily accessed through Our member site at www.cdphp.com or by calling Our member services department at the number on Your ID card.

[C.] National Diabetes Prevention Program

1. Purpose.

The Diabetes Prevention Program helps You take control of Your health by adopting habits to reduce Your chances of developing type 2 diabetes and improve Your overall health and well-being. The CDC-led National Diabetes Prevention Program is an evidence-based lifestyle change program for preventing type 2 diabetes. Diabetes Prevention Programs encourages collaboration among federal agencies, community-based organizations, employers, insurers, health care professionals, academia, and other stakeholders to prevent or delay the onset of type 2 diabetes among people with pre-diabetes.

2. Description.

- The Diabetes Prevention Program is a year-long program that helps participants make real lifestyle changes such as eating healthier, including physical activity into their daily lives, and improving problem-solving and coping skills. Participants meet with a trained Lifestyle Coach and a small group of people in a classroom or on-line setting to learn about healthier eating and increasing their physical activity in order to reduce their risk for developing type 2 diabetes. The program, which is led by a trained Lifestyle Coach in a classroom setting, is generally delivered over a 12-month period, beginning with 16 weekly sessions followed by monthly maintenance (sessions are usually weekly for 6 months and then monthly for 6 months.) The National Diabetes Prevention Program can help people make achievable and realistic lifestyle changes and cut their risk of developing type 2 diabetes

3. Eligibility.

You, the Subscriber, can participate in the Diabetes Prevention Program. Participation and preauthorization requirements for the program, as well as descriptions of activities available, can be easily accessed through Our member site at www.cdphp.com or by calling Our member services department at the number on Your ID card.

[D.] Weight Loss Program Reimbursement

Members who participate in a weight loss program with a preferred vendor are eligible for a once per Plan Year partial reimbursement for a completed program.

Conditions for Reimbursement

- The reimbursement is only allowed once per Benefit Period.
- Members must attend and pay for the weight loss program.
- Members must have the weight loss program instructor sign a confirmation form, attesting that the program has been completed.

Reimbursement

The completed form should not be photocopied, the reimbursement is nontransferable.

Members can mail the original copy of the completed reimbursement form to:

CDPHP Claims Dept.
PO Box 66602
Albany, NY 12206-6602; or

The form can be submitted electronically by:

Logging-into the secure member portal at www.cdphp.com and selecting the “Mail Center” icon to submit claims via secure email.

SECTION XIV

Exclusions and Limitations

No coverage is available under this Certificate for the following:

A. Aviation.

We do not Cover services arising out of aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.

B. Convalescent and Custodial Care.

We do not Cover services related to rest cures, custodial care or transportation. "Custodial care" means help in transferring, eating, dressing, bathing, toileting and other such related activities. Custodial care does not include Covered Services determined to be Medically Necessary.

C. Conversion Therapy.

We do not Cover conversion therapy. Conversion therapy is any practice by a mental health professional that seeks to change the sexual orientation or gender identity of a Member under 18 years of age, including efforts to change behaviors, gender expressions, or to eliminate or reduce sexual or romantic attractions or feelings toward individuals of the same sex. Conversion therapy does not include counseling or therapy for an individual who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition, that provides acceptance, support, and understanding of an individual or the facilitation of an individual's coping, social support, and identity exploration and development, including sexual orientation-neutral interventions to prevent or address unlawful conduct or unsafe sexual practices, provided that the counseling or therapy does not seek to change sexual orientation or gender identity.

D. Cosmetic Services.

We do not Cover cosmetic services, Prescription Drugs, or surgery, unless otherwise specified, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or diseases of the involved part, and reconstructive surgery because of congenital disease or anomaly of a covered Child which has resulted in a functional defect. We also Cover services in connection with reconstructive surgery following a mastectomy, as provided elsewhere in this Certificate. Cosmetic surgery does not include surgery determined to be Medically Necessary. If a claim for a procedure listed in 11 NYCRR 56 (e.g., certain plastic surgery and dermatology procedures) is submitted retrospectively and without medical information, any denial will not be subject to the Utilization Review process in the Utilization Review and External Appeal sections of this Certificate unless medical information is submitted.

E. Coverage Outside of the United States, Canada or Mexico.

We do not Cover care or treatment provided outside of the United States, its possessions, Canada or Mexico except for Emergency Services, Pre-Hospital Emergency Medical Services and ambulance services to treat Your Emergency Condition.

F. Dental Services.

We do not Cover dental services except for: care or treatment due to accidental injury to sound natural teeth within 12 months of the accident; dental care or treatment necessary due to congenital disease or anomaly; or dental care or treatment specifically stated in the Outpatient and Professional Services section of this Certificate.

G. Experimental or Investigational Treatment.

We do not Cover any health care service, procedure, treatment, device or Prescription Drug that is experimental or investigational. However, We will Cover experimental or investigational treatments, including treatment for Your rare disease or patient costs for Your participation in a clinical trial as described in the Outpatient and Professional Services section of this Certificate, when Our denial of services is overturned by an External Appeal Agent certified by the State. However, for clinical trials, We will not Cover the costs of any investigational drugs or devices, non-health services required for You to receive the treatment, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments. See the Utilization Review and External Appeal sections of this Certificate for a further explanation of Your Appeal rights.

H. Felony Participation.

We do not Cover any illness, treatment or medical condition due to Your participation in a felony, riot or insurrection. This exclusion does not apply to Coverage for services involving injuries suffered by a victim of an act of domestic violence or for services as a result of Your medical condition (including both physical and mental health conditions).

I. Foot Care.

We do not Cover routine foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. However, we will Cover foot care when You have a specific medical condition or disease resulting in circulatory deficits or areas of decreased sensation in Your legs or feet.

J. Government Facility.

We do not Cover care or treatment provided in a Hospital that is owned or operated by any federal, state or other governmental entity, except as otherwise required by law unless You are taken to the Hospital because it is close to the place where You were injured or became ill and Emergency Services are provided to treat Your Emergency Condition.

K. Medically Necessary.

In general, We will not Cover any health care service, procedure, treatment, test, device

or Prescription Drug that We determine is not Medically Necessary. If an External Appeal Agent certified by the State overturns Our denial, however, We will Cover the service, procedure, treatment, test, device or Prescription Drug for which coverage has been denied, to the extent that such service, procedure, treatment, test, device or Prescription Drug is otherwise Covered under the terms of this Certificate.

L. Medicare or Other Governmental Program.

We do not Cover services if benefits are provided for such services under the federal Medicare program or other governmental program (except Medicaid).

M. Military Service.

We do not Cover an illness, treatment or medical condition due to service in the Armed Forces or auxiliary units.

N. No-Fault Automobile Insurance.

We do not Cover any benefits to the extent provided for any loss or portion thereof for which mandatory automobile no-fault benefits are recovered or recoverable. This exclusion applies even if You do not make a proper or timely claim for the benefits available to You under a mandatory no-fault policy.

O. Services Not Listed.

We do not Cover services that are not listed in this Certificate as being Covered.

P. Services Provided by a Family Member.

We do not Cover services performed by a member of the covered person's immediate family. "Immediate family" shall mean a child, spouse, mother, father, sister or brother of You or Your Spouse.

Q. Services Separately Billed by Hospital Employees.

We do not Cover services rendered and separately billed by employees of Hospitals, laboratories or other institutions.

R. Services with No Charge.

We do not Cover services for which no charge is normally made.

S. Vision Services.

We do not Cover the examination or fitting of eyeglasses or contact lenses.

T. War.

We do not Cover an illness, treatment or medical condition due to war, declared or undeclared.

U. Workers' Compensation.

We do not Cover services if benefits for such services are provided under any state or federal Workers' Compensation, employers' liability or occupational disease law.

SECTION XV

Claim Determinations

A. Claims.

A claim is a request that benefits or services be provided or paid according to the terms of this Certificate. When You receive services from a Participating Provider, You will not need to submit a claim form. However, if You receive services from a Non-Participating Provider either You or the Provider must file a claim form with Us. If the Non-Participating Provider is not willing to file the claim form, You will need to file it with Us. See the Coordination of Benefits section of this Certificate for information on how We coordinate benefit payments when You also have group health coverage with another plan.

B. Notice of Claim.

Claims for services must include all information designated by Us as necessary to process the claim, including, but not limited to: Member identification number; name; date of birth; date of service; type of service; the charge for each service; procedure code for the service as applicable; diagnosis code; name and address of the Provider making the charge; and supporting medical records, when necessary. A claim that fails to contain all necessary information will not be accepted and must be resubmitted with all necessary information. Claim forms are available from Us by calling the number on Your ID card or visiting Our website at www.cdphp.com. Completed claim forms should be sent to the address in the How Your Coverage Works section of this Certificate. You may also submit a claim to Us electronically by sending it to the e-mail address in the How Your Coverage Works section of this Certificate or visiting Our website at www.cdphp.com.

C. Timeframe for Filing Claims.

Claims for services must be submitted to Us for payment within 12 months after You receive the services for which payment is being requested. If it is not reasonably possible to submit a claim within the 12-month period, You must submit it as soon as reasonably possible.

D. Claims for Prohibited Referrals.

We are not required to pay any claim, bill or other demand or request by a Provider for clinical laboratory services, pharmacy services, radiation therapy services, physical therapy services or x-ray or imaging services furnished pursuant to a referral prohibited by Section 238-a(1) of the New York Public Health Law.

E. Claim Determinations.

Our claim determination procedure applies to all claims that do not relate to a medical necessity or experimental or investigational determination. For example, Our claim determination procedure applies to contractual benefit denials. If You disagree with Our claim determination, You may submit a Grievance pursuant to the Grievance

Procedures section of this Certificate.

For a description of the Utilization Review procedures and Appeal process for medical necessity or experimental or investigational determinations, see the Utilization Review and External Appeal sections of this Certificate.

F. Pre-Service Claim Determinations.

1. A pre-service claim is a request that a service or treatment be approved before it has been received. If We have all the information necessary to make a determination regarding a pre-service claim (e.g., a covered benefit determination Certificate), We will make a determination and provide notice to You (or Your designee) within 15 days from receipt of the claim.

If We need additional information, We will request it within 15 days from receipt of the claim. You will have 45 calendar days to submit the information. If We receive the information within 45 days, We will make a determination and provide notice to You (or Your designee) in writing, within 15 days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the end of the 45-day period.

2. **Urgent Pre-Service Reviews.** With respect to urgent pre-service requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) by telephone, within 72 hours of receipt of the request. Written notice will follow within three (3) calendar days of the decision. If We need additional information, We will request it within 24 hours. You will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) by telephone within 48 hours of the earlier of Our receipt of the information or the end of the 48-hour period. Written notice will follow within three (3) calendar days of the decision.

G. Post-Service Claim Determinations.

A post-service claim is a request for a service or treatment that You have already received. If We have all information necessary to make a determination regarding a post-service claim, We will make a determination and notify You (or Your designee) within 30 calendar days of the receipt of the claim if We deny the claim in whole or in part. If We need additional information, We will request it within 30 calendar days. You will then have 45 calendar days to provide the information. We will make a determination and provide notice to You (or Your designee) in writing within 15 calendar days of the earlier of Our receipt of the information or the end of the 45-day period if We deny the claim in whole or in part.

H. Payment of Claims.

Where Our obligation to pay a claim is reasonably clear, We will pay the claim within 30 days of receipt of the claim (when submitted through the internet or e-mail) and 45 days

of receipt of the claim (when submitted through other means, including paper or fax). If We request additional information, We will pay the claim within 30 days (for claims submitted through the internet or e-mail) or 45 days (for claims submitted through other means, including paper or fax) of receipt of the information.



SECTION XVI

Grievance Procedures

A. Grievances.

Our Grievance procedure applies to any issue not relating to a Medical Necessity or experimental or investigational determination by Us. For example, it applies to contractual benefit denials or issues or concerns You have regarding Our administrative policies or access to Providers.

B. Filing a Grievance.

You can contact Us by phone at the number on Your ID card, in person, or in writing to file a Grievance. You must use Our Grievance form for written Grievances. You may submit an oral Grievance in connection with a denial of a Referral or a covered benefit determination. We may require that You sign a written acknowledgement of Your oral Grievance, prepared by Us. You or Your designee has up to 180 calendar days from when You received the decision You are asking Us to review to file the Grievance.

When We receive Your Grievance, We will mail an acknowledgment letter within 15 business days. The acknowledgment letter will include the name, address, and telephone number of the person handling Your Grievance, and indicate what additional information, if any, must be provided.

We keep all requests and discussions confidential and We will take no discriminatory action because of Your issue. We have a process for both standard and expedited Grievances, depending on the nature of Your inquiry.

C. Grievance Determination.

Qualified personnel will review Your Grievance, or if it is a clinical matter, a licensed, certified or registered Health Care Professional will look into it. We will decide the Grievance and notify You within the following timeframes:

Expedited/Urgent Grievances:

By phone, within the earlier of 48 hours of receipt of all necessary information or 72 hours of receipt of Your Grievance. Written notice will be provided within 72 hours of receipt of Your Grievance.

Pre-Service Grievances:

(A request for a service or treatment that has not yet been provided.)

In writing, within 15 calendar days of receipt of Your Grievance.

Post-Service Grievances:

(A claim for a service or treatment that has already been provided.)

In writing, within 30 calendar days of receipt of Your Grievance.

All Other Grievances:
(That are not in relation to a claim or request for a service or treatment.)

In writing, within 45 calendar days of receipt of all necessary information but no more than 60 calendar days of receipt of Your Grievance.

D. Grievance Appeals.

If You are not satisfied with the resolution of Your Grievance, You or Your designee may file an Appeal by phone at the number on Your ID card, in person, or in writing. You have up to 60 business days from receipt of the Grievance determination to file an Appeal.

When We receive Your Appeal, We will mail an acknowledgment letter within 15 business days. The acknowledgement letter will include the name, address, and telephone number of the person handling Your Appeal and indicate what additional information, if any, must be provided.

One or more qualified personnel at a higher level than the personnel that rendered the Grievance determination will review it, or if it is a clinical matter, a clinical peer reviewer will look into it. We will decide the Appeal and notify You in writing within the following timeframes:

Expedited/Urgent Grievances:

The earlier of two (2) business days of receipt of all necessary information or 72 hours of receipt of Your Appeal.

Pre-Service Grievances:
(A request for a service or treatment that has not yet been provided.)

15 calendar days of receipt of Your Appeal.

Post-Service Grievances:
(A claim for a service or treatment that has already been provided.)

30 calendar days of receipt of Your Appeal.

All Other Grievances: (That are not in relation to a claim or request for a service or treatment.)

30 business days of receipt of all necessary information to make a determination.

E. Assistance.

If You remain dissatisfied with Our Appeal determination, or at any other time You are dissatisfied, You may:

Call the New York State Department of Health at 1-800-206-8125 or write them at:
New York State Department of Health

Office of Health Insurance Programs
Bureau of Consumer Services – Complaint Unit
Corning Tower – OCP Room 1609
Albany, NY 12237
Email: managedcarecomplaint@health.ny.gov
Website: www.health.ny.gov

If You need assistance filing a Grievance or Appeal, You may also contact the state independent Consumer Assistance Program at:

Community Health Advocates
633 Third Avenue, 10th Floor
New York, NY 10017
Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org
Website: www.communityhealthadvocates.org

SECTION XVII

Utilization Review

A. Utilization Review.

We review health services to determine whether the services are or were Medically Necessary or experimental or investigational ("Medically Necessary"). This process is called Utilization Review. Utilization Review includes all review activities, whether they take place prior to the service being performed (Preauthorization); when the service is being performed (concurrent); or after the service is performed (retrospective). If You have any questions about the Utilization Review process, please call the number on Your ID card. The toll-free telephone number is available at least 40 hours a week with an after-hours answering machine.

All determinations that services are not Medically Necessary will be made by: 1) licensed Physicians; or 2) licensed, certified, registered or credentialed Health Care Professionals who are in the same profession and same or similar specialty as the Provider who typically manages Your medical condition or disease or provides the health care service under review; or 3) with respect to mental health or substance use disorder treatment, licensed Physicians or licensed, certified, registered or credentialed Health Care Professionals who specialize in behavioral health and have experience in the delivery of mental health or substance use disorder courses of treatment. We do not compensate or provide financial incentives to Our employees or reviewers for determining that services are not Medically Necessary.

We have developed guidelines and protocols to assist Us in this process. For substance use disorder treatment, We will use evidence-based and peer reviewed clinical review tools designated by OASAS that are appropriate to the age of the patient. Specific guidelines and protocols are available for Your review upon request. For more information, call the number on Your ID card or visit Our website at www.cdphp.com.

B. Preauthorization Reviews.

1. **Non-Urgent Preauthorization Reviews.** If We have all the information necessary to make a determination regarding a Preauthorization review, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of receipt of the request.

If We need additional information, We will request it within three (3) business days. You or Your Provider will then have 45 calendar days to submit the information. If We receive the requested information within 45 days, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within three (3) business days of Our receipt of the information. If all necessary information is not received within 45 days, We will make a determination within 15 calendar days of the earlier of the

receipt of part of the requested information or the end of the 45-day period.

2. **Urgent Preauthorization Reviews.** With respect to urgent Preauthorization requests, if We have all information necessary to make a determination, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone, within 72 hours of receipt of the request. Written notice will be provided within three (3) business days of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone and in writing within 48 hours of the earlier of Our receipt of the information or the end of the 48 hour period.
3. **Court Ordered Treatment.** With respect to requests for mental health and/or substance use disorder services that have not yet been provided, if You (or Your designee) certify, in a format prescribed by the Superintendent of Financial Services, that You will be appearing, or have appeared, before a court of competent jurisdiction and may be subject to a court order requiring such services, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 72 hours of receipt of the request. Written notification will be provided within three (3) business days of Our receipt of the request. Where feasible, the telephonic and written notification will also be provided to the court.
4. **Inpatient Rehabilitation Services Reviews.** After receiving a Preauthorization request for coverage of inpatient rehabilitation services following an inpatient Hospital admission provided by a Hospital or skilled nursing facility, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information.

C. Concurrent Reviews.

1. **Non-Urgent Concurrent Reviews.** Utilization Review decisions for services during the course of care (concurrent reviews) will be made, and notice provided to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of all necessary information. If We need additional information, We will request it within one (1) business day. You or Your Provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of Our receipt of the information or, if We do not receive the information, within the earlier of 15 calendar days of the receipt of part of the requested information or 15 calendar days of the end of the 45-day period.

2. **Urgent Concurrent Reviews.** For concurrent reviews that involve an extension of urgent care, if the request for coverage is made at least 24 hours prior to the expiration of a previously approved treatment, We will make a determination and provide notice to You (or Your designee) and Your Provider by telephone within 24 hours of receipt of the request. Written notice will be provided within one (1) business day of receipt of the request.

If the request for coverage is not made at least 24 hours prior to the expiration of a previously approved treatment and We have all the information necessary to make a determination, We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of 72 hours or one (1) business day of receipt of the request. If We need additional information, We will request it within 24 hours. You or Your Provider will then have 48 hours to submit the information. We will make a determination and provide written notice to You (or Your designee) and Your Provider within the earlier of one (1) business day or 48 hours of Our receipt of the information or, if we do not receive the information, within 48 hours of the end of the 48-hour period.

3. **Home Health Care Reviews.** After receiving a request for coverage of home care services following an inpatient Hospital admission, We will make a determination and provide notice to You (or Your designee) and Your Provider, by telephone and in writing, within one (1) business day of receipt of the necessary information. If the day following the request falls on a weekend or holiday, We will make a determination and provide notice to You (or Your designee) and Your Provider within 72 hours of receipt of the necessary information. When We receive a request for home care services and all necessary information prior to Your discharge from an inpatient hospital admission, We will not deny coverage for home care services while Our decision on the request is pending.
4. **Inpatient Substance Use Disorder Treatment Reviews.** If a request for inpatient substance use disorder treatment is submitted to Us at least 24 hours prior to discharge from an inpatient substance use disorder treatment admission, We will make a determination within 24 hours of receipt of the request and We will provide coverage for the inpatient substance use disorder treatment while Our determination is pending.
5. **Inpatient Mental Health Treatment for Members under 18 at Participating Hospitals Licensed by the Office of Mental Health (OMH).** Coverage for inpatient mental health treatment at a participating OMH-licensed Hospital is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 14 days of the inpatient admission if the OMH-licensed Hospital notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 14 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary, and We

will use clinical review tools approved by OMH. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.

- 6. Inpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for inpatient substance use disorder treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first 28 days of the inpatient admission if the OASAS-certified Facility notifies Us of both the admission and the initial treatment plan within two (2) business days of the admission. After the first 28 days of the inpatient admission, We may review the entire stay to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the stay is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your inpatient admission.
- 7. Outpatient Substance Use Disorder Treatment at Participating OASAS-Certified Facilities.** Coverage for outpatient, intensive outpatient, outpatient rehabilitation and opioid treatment at a participating OASAS-certified Facility is not subject to Preauthorization. Coverage will not be subject to concurrent review for the first four (4) weeks of continuous treatment, not to exceed 28 visits, if the OASAS-certified Facility notifies Us of both the start of treatment and the initial treatment plan within two (2) business days. After the first four (4) weeks of continuous treatment, not to exceed 28 visits, We may review the entire outpatient treatment to determine whether it is Medically Necessary and We will use clinical review tools designated by OASAS. If any portion of the outpatient treatment is denied as not Medically Necessary, You are only responsible for the in-network Cost-Sharing that would otherwise apply to Your outpatient treatment.

D. Retrospective Reviews.

If We have all information necessary to make a determination regarding a retrospective claim, We will make a determination and notify You and Your Provider within 30 calendar days of the receipt of the request. If We need additional information, We will request it within 30 calendar days. You or Your Provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to You and Your Provider in writing within 15 calendar days of the earlier of Our receipt of all or part of the requested information or the end of the 45-day period.

Once We have all the information to make a decision, Our failure to make a Utilization Review determination within the applicable time frames set forth above will be deemed an adverse determination subject to an internal Appeal.

E. Retrospective Review of Preauthorized Services.

We may only reverse a preauthorized treatment, service or procedure on retrospective review when:

- The relevant medical information presented to Us upon retrospective review is materially different from the information presented during the Preauthorization review;
- The relevant medical information presented to Us upon retrospective review existed at the time of the Preauthorization but was withheld or not made available to Us;
- We were not aware of the existence of such information at the time of the Preauthorization review; and
- Had We been aware of such information, the treatment, service or procedure being requested would not have been authorized. The determination is made using the same specific standards, criteria or procedures as used during the Preauthorization review.

F. Step Therapy Override Determinations.

You, Your designee, or Your Health Care Professional may request a step therapy protocol override determination for Coverage of a Prescription Drug selected by Your Health Care Professional. When conducting Utilization Review for a step therapy protocol override determination, We will use recognized evidence-based and peer reviewed clinical review criteria that is appropriate for You and Your medical condition.

- 1. Supporting Rationale and Documentation.** A step therapy protocol override determination request must include supporting rationale and documentation from a Health Care Professional, demonstrating that:
 - The required Prescription Drug(s) is contraindicated or will likely cause an adverse reaction or physical or mental harm to You;
 - The required Prescription Drug(s) is expected to be ineffective based on Your known clinical history, condition, and Prescription Drug regimen;
 - You have tried the required Prescription Drug(s) while covered by Us or under Your previous health insurance coverage, or another Prescription Drug in the same pharmacologic class or with the same mechanism of action, and that Prescription Drug(s) was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;
 - You are stable on a Prescription Drug(s) selected by Your Health Care Professional for Your medical condition, provided this does not prevent Us from requiring You to try an AB-rated generic equivalent; or
 - The required Prescription Drug(s) is not in Your best interest because it will likely cause a significant barrier to Your adherence to or compliance with Your plan of care, will likely worsen a comorbid condition, or will likely decrease Your ability to achieve or maintain reasonable functional ability in performing daily activities.
- 2. Standard Review.** We will make a step therapy protocol override determination and provide notification to You (or Your designee) and where appropriate, Your Health Care Professional, within 72 hours of receipt of the supporting rationale and documentation.

3. Expedited Review. If You have a medical condition that places Your health in serious jeopardy without the Prescription Drug prescribed by Your Health Care Professional, We will make a step therapy protocol override determination and provide notification to You (or Your designee) and Your Health Care Professional within 24 hours of receipt of the supporting rationale and documentation.

If the required supporting rationale and documentation are not submitted with a step therapy protocol override determination request, We will request the information within 72 hours for Preauthorization and retrospective reviews, the lesser of 72 hours or one (1) business day for concurrent reviews, and 24 hours for expedited reviews. You or Your Health Care Professional will have 45 calendar days to submit the information for Preauthorization, concurrent and retrospective reviews, and 48 hours for expedited reviews. For Preauthorization reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For concurrent reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours or one (1) business day of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For retrospective reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 72 hours of Our receipt of the information or 15 calendar days of the end of the 45-day period if the information is not received. For expedited reviews, We will make a determination and provide notification to You (or Your designee) and Your Health Care Professional within the earlier of 24 hours of Our receipt of the information or 48 hours of the end of the 48-hour period if the information is not received.

If We do not make a determination within 72 hours (or 24 hours for expedited reviews) of receipt of the supporting rationale and documentation, the step therapy protocol override request will be approved.

If We determine that the step therapy protocol should be overridden, We will authorize immediate coverage for the Prescription Drug prescribed by Your treating Health Care Professional. An adverse step therapy override determination is eligible for an Appeal.

G. Reconsideration.

If We did not attempt to consult with Your Provider who recommended the Covered Service before making an adverse determination, the Provider may request reconsideration by the same clinical peer reviewer who made the adverse determination or a designated clinical peer reviewer if the original clinical peer reviewer is unavailable. For Preauthorization and concurrent reviews, the reconsideration will take place within one (1) business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to You and Your Provider, by telephone and in writing.

H. Utilization Review Internal Appeals.

You, Your designee, and, in retrospective review cases, Your Provider, may request an internal Appeal of an adverse determination, either by phone, in person, or in writing.

You have up to 180 calendar days after You receive notice of the adverse determination to file an Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will if necessary, inform You of any additional information needed before a decision can be made. The Appeal will be decided by a clinical peer reviewer who is not subordinate to the clinical peer reviewer who made the initial adverse determination and who is 1) a Physician or 2) a Health Care Professional in the same or similar specialty as the Provider who typically manages the disease or condition at issue.

1. **Out-of-Network Service Denial.** You also have the right to Appeal the denial of a Preauthorization request for an out-of-network health service when We determine that the out-of-network health service is not materially different from an available in-network health service. A denial of an out-of-network health service is a service provided by a Non-Participating Provider, but only when the service is not available from a Participating Provider. For a Utilization Review Appeal of denial of an out-of-network health service, You or Your designee must submit:
 - A written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition, that the requested out-of-network health service is materially different from the alternate health service available from a Participating Provider that We approved to treat Your condition; and
 - Two (2) documents from the available medical and scientific evidence that the out-of-network service: 1) is likely to be more clinically beneficial to You than the alternate in-network service; and 2) that the adverse risk of the out-of-network service would likely not be substantially increased over the in-network health service.

2. **Out-of-Network Referral Denial.** You also have the right to Appeal the denial of a request for a Referral to a Non-Participating Provider when We determine that We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service. For a Utilization Review Appeal of an out-of-network Referral denial, You or Your designee must submit a written statement from Your attending Physician, who must be a licensed, board-certified or board-eligible Physician qualified to practice in the specialty area of practice appropriate to treat Your condition:
 - That the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs for the health care service; and

- Recommending a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

I. First Level Appeal.

1. **Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
2. **Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within the earlier of 30 calendar days of receipt of the information necessary to conduct the Appeal or 60 days of receipt of the Appeal. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
3. **Expedited Appeal.** An Appeal of a review of continued or extended health care services, additional services rendered in the course of continued treatment, home health care services following discharge from an inpatient Hospital admission, services in which a Provider requests an immediate review, mental health and/or substance use disorder services that may be subject to a court order, or any other urgent matter will be handled on an expedited basis. An expedited Appeal is not available for retrospective reviews. For an expedited Appeal, Your Provider will have reasonable access to the clinical peer reviewer assigned to the Appeal within one (1) business day of receipt of the request for an Appeal. Your Provider and a clinical peer reviewer may exchange information by telephone or fax. An expedited Appeal will be determined within the earlier of 72 hours of receipt of the Appeal or two (2) business days of receipt of the information necessary to conduct the Appeal. Written notice of the determination will be provided to You (or Your designee) within 24 hours after the determination is made, but no later than 72 hours after receipt of the Appeal request.

If You are not satisfied with the resolution of Your expedited Appeal, You may file a standard internal Appeal or an external appeal.

Our failure to render a determination of Your Appeal within 30 calendar days of receipt of the necessary information for a standard Appeal or within two (2) business days of receipt of the necessary information for an expedited Appeal will be deemed a reversal of the initial adverse determination.

4. **Substance Use Appeal.** If We deny a request for inpatient substance use

disorder treatment that was submitted at least 24 hours prior to discharge from an inpatient admission, and You or Your Provider file an expedited internal Appeal of Our adverse determination, We will decide the Appeal within 24 hours of receipt of the Appeal request. If You or Your Provider file the expedited internal Appeal and an expedited external appeal within 24 hours of receipt of Our adverse determination, We will also provide coverage for the inpatient substance use disorder treatment while a determination on the internal Appeal and external appeal is pending.

J. Full and Fair Review of an Appeal.

We will provide You, free of charge, with any new or additional evidence considered, relied upon, or generated by Us or any new or additional rationale in connection with Your Appeal. The evidence or rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse determination is required to be provided to give You a reasonable opportunity to respond prior to that date.

K. Second Level Appeal.

If You disagree with the first level Appeal determination, You or Your designee can file a second level Appeal. You or Your designee can also file an external appeal. **The four (4) month timeframe for filing an external appeal begins on receipt of the final adverse determination on the first level of Appeal. By choosing to file a second level Appeal, the time may expire for You to file an external appeal.**

A second level Appeal must be filed within 45 days of receipt of the final adverse determination on the first level Appeal. We will acknowledge Your request for an internal Appeal within 15 calendar days of receipt. This acknowledgment will inform You, if necessary, of any additional information needed before a decision can be made.

- 1. Preauthorization Appeal.** If Your Appeal relates to a Preauthorization request, We will decide the Appeal within 15 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 15 calendar days after receipt of the Appeal request.
- 2. Retrospective Appeal.** If Your Appeal relates to a retrospective claim, We will decide the Appeal within 30 calendar days of receipt of the Appeal request. Written notice of the determination will be provided to You (or Your designee), and where appropriate, Your Provider, within two (2) business days after the determination is made, but no later than 30 calendar days after receipt of the Appeal request.
- 3. Expedited Appeal.** If Your Appeal relates to an urgent matter, We will decide the Appeal and provide written notice of the determination to You (or Your

designee), and where appropriate, Your Provider, within 72 hours of receipt of the Appeal request.

L. Appeal Assistance.

If You need Assistance filing an Appeal, You may contact the state independent Consumer Assistance Program at:

Community Health Advocates

633 Third Avenue, 10th Floor

New York, NY 10017

Or call toll free: 1-888-614-5400, or e-mail cha@cssny.org

Website: www.communityhealthadvocates.org

SECTION XVIII

External Appeal

A. Your Right to an External Appeal.

In some cases, You have a right to an external appeal of a denial of coverage. If We have denied coverage on the basis that a service is not Medically Necessary (including appropriateness, health care setting, level of care or effectiveness of a Covered benefit); or is an experimental or investigational treatment (including clinical trials and treatments for rare diseases); or is an out-of-network treatment, You or Your representative may appeal that decision to an External Appeal Agent, an independent third party certified by the State to conduct these appeals.

In order for You to be eligible for an external appeal You must meet the following two (2) requirements:

- The service, procedure, or treatment must otherwise be a Covered Service under this Certificate; and
- In general, You must have received a final adverse determination through the first level of Our internal Appeal process. But, You can file an external appeal even though You have not received a final adverse determination through the first level of Our internal Appeal process if:
 - We agree in writing to waive the internal Appeal. We are not required to agree to Your request to waive the internal Appeal; or
 - You file an external appeal at the same time as You apply for an expedited internal Appeal; or
 - We fail to adhere to Utilization Review claim processing requirements (other than a minor violation that is not likely to cause prejudice or harm to You, and We demonstrate that the violation was for good cause or due to matters beyond Our control and the violation occurred during an ongoing, good faith exchange of information between You and Us).

B. Your Right to Appeal a Determination that a Service is Not Medically Necessary.

If We have denied coverage on the basis that the service is not Medically Necessary, You may appeal to an External Appeal Agent if You meet the requirements for an external appeal in paragraph “A” above.

C. Your Right to Appeal a Determination that a Service is Experimental or Investigational.

If We have denied coverage on the basis that the service is an experimental or investigational treatment (including clinical trials and treatments for rare diseases), You must satisfy the two (2) requirements for an external appeal in paragraph “A” above and Your attending Physician must certify that Your condition or disease is one for which:

1. Standard health services are ineffective or medically inappropriate; or

2. There does not exist a more beneficial standard service or procedure Covered by Us; or
3. There exists a clinical trial or rare disease treatment (as defined by law).

In addition, Your attending Physician must have recommended one (1) of the following:

1. A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to You than any standard Covered Service (only certain documents will be considered in support of this recommendation – Your attending Physician should contact the State for current information as to what documents will be considered or acceptable); or
2. A clinical trial for which You are eligible (only certain clinical trials can be considered); or
3. A rare disease treatment for which Your attending Physician certifies that there is no standard treatment that is likely to be more clinically beneficial to You than the requested service, the requested service is likely to benefit You in the treatment of Your rare disease, and such benefit outweighs the risk of the service. In addition, Your attending Physician must certify that Your condition is a rare disease that is currently or was previously subject to a research study by the National Institutes of Health Rare Disease Clinical Research Network or that it affects fewer than 200,000 U.S. residents per year.

For purposes of this section, Your attending Physician must be a licensed, board-certified or board eligible Physician qualified to practice in the area appropriate to treat Your condition or disease. In addition, for a rare disease treatment, the attending Physician may not be Your treating Physician.

D. Your Right to Appeal a Determination that a Service is Out-of-Network.

If We have denied coverage of an out-of-network treatment because it is not materially different than the health service available in-network, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph “A” above, and You have requested Preauthorization for the out-of-network treatment.

In addition, Your attending Physician must certify that the out-of-network service is materially different from the alternate recommended in-network health service, and based on two (2) documents from available medical and scientific evidence, is likely to be more clinically beneficial than the alternate in-network treatment and that the adverse risk of the requested health service would likely not be substantially increased over the alternate in-network health service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

E. Your Right to Appeal an Out-of-Network Referral Denial to a Non-Participating Provider.

If We have denied coverage of a request for a Referral to a Non-Participating Provider because We determine We have a Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service, You may appeal to an External Appeal Agent if You meet the two (2) requirements for an external appeal in paragraph "A" above.

In addition, Your attending Physician must: 1) certify that the Participating Provider recommended by Us does not have the appropriate training and experience to meet Your particular health care needs; and 2) recommend a Non-Participating Provider with the appropriate training and experience to meet Your particular health care needs who is able to provide the requested health care service.

For purposes of this section, Your attending Physician must be a licensed, board certified or board eligible Physician qualified to practice in the specialty area appropriate to treat You for the health service.

F. Your Right to Appeal a Formulary Exception Denial.

If We have denied Your request for coverage of a non-formulary Prescription Drug through Our formulary exception process, You, Your designee or the prescribing Health Care Professional may appeal the formulary exception denial to an External Appeal Agent. See the Prescription Drug Coverage section of this Certificate for more information on the formulary exception process.

G. The External Appeal Process.

You have four (4) months from receipt of a final adverse determination or from receipt of a waiver of the internal Appeal process to file a written request for an external appeal. If You are filing an external appeal based on Our failure to adhere to claim processing requirements, You have four (4) months from such failure to file a written request for an external appeal.

We will provide an external appeal application with the final adverse determination issued through the first level of Our internal Appeal process or Our written waiver of an internal Appeal. You may also request an external appeal application from the New York State Department of Financial Services at 1-800-400-8882. Submit the completed application to the Department of Financial Services at the address indicated on the application. If You meet the criteria for an external appeal, the State will forward the request to a certified External Appeal Agent.

You can submit additional documentation with Your external appeal request. If the External Appeal Agent determines that the information You submit represents a material change from the information on which We based Our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three (3) business days to amend or confirm Our decision. Please note that in the case of an expedited external appeal (described below), We do not have a right to reconsider Our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of Your completed application. The External Appeal Agent may request additional information from You, Your Physician, or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify You in writing of its decision within two (2) business days.

If Your attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to Your health; or if Your attending Physician certifies that the standard external appeal time frame would seriously jeopardize Your life, health or ability to regain maximum function; or if You received Emergency Services and have not been discharged from a Facility and the denial concerns an admission, availability of care or continued stay, You may request an expedited external appeal. In that case, the External Appeal Agent must make a decision within 72 hours of receipt of Your completed application. Immediately after reaching a decision, the External Appeal Agent must notify You and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify You in writing of its decision.

If Your internal formulary exception request received a standard review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 72 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within two (2) business days of making a determination. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

If Your internal formulary exception request received an expedited review through Our formulary exception process, the External Appeal Agent must make a decision on Your external appeal and notify You or Your designee and the prescribing Health Care Professional by telephone within 24 hours of receipt of Your completed application. The External Appeal Agent will notify You or Your designee and the prescribing Health Care Professional in writing within 72 hours of receipt of Your completed application. If the External Appeal Agent overturns Our denial, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-formulary Prescription Drug.

If the External Appeal Agent overturns Our decision that a service is not Medically Necessary or approves coverage of an experimental or investigational treatment or an out-of-network treatment, We will provide coverage subject to the other terms and conditions of this Certificate. Please note that if the External Appeal Agent approves coverage of an experimental or investigational treatment that is part of a clinical trial,

We will only Cover the cost of services required to provide treatment to You according to the design of the trial. We will not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing the research, or costs that would not be Covered under this Certificate for non-investigational treatments provided in the clinical trial.

The External Appeal Agent's decision is binding on both You and Us. The External Appeal Agent's decision is admissible in any court proceeding.

H. Your Responsibilities.

It is Your responsibility to start the external appeal process. You may start the external appeal process by filing a completed application with the New York State Department of Financial Services. You may appoint a representative to assist You with Your application; however, the Department of Financial Services may contact You and request that You confirm in writing that You have appointed the representative.

Under New York State law, Your completed request for external appeal must be filed within four (4) months of either the date upon which You receive a final adverse determination, or the date upon which You receive a written waiver of any internal Appeal, or Our failure to adhere to claim processing requirements. We have no authority to extend this deadline.

SECTION XIX

Coordination of Benefits

This section applies when You also have group health coverage with another plan. When You receive a Covered Service, We will coordinate benefit payments with any payment made by another plan. The primary plan will pay its full benefits and the other plan may pay secondary benefits, if necessary, to cover some or all of the remaining expenses. This coordination prevents duplicate payments and overpayments. We do not coordinate benefit payments for vision benefits.

A. Definitions.

1. **“Allowable expense”** is the necessary, reasonable, and customary item of expense for health care, when the item is covered at least in part under any of the plans involved, except where a statute requires a different definition. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered as both an allowable expense and a benefit paid.
2. **“Plan”** is other group health coverage with which We will coordinate benefits. The term “plan” includes:
 - Group health benefits and group blanket or group remittance health benefits coverage, whether insured, self-insured, or self-funded. This includes group HMO and other prepaid group coverage, but does not include blanket school accident coverage or coverages issued to a substantially similar group (e.g., Girl Scouts, Boy Scouts) where the school or organization pays the premiums.
 - Medical benefits coverage, in group and individual automobile “no-fault” and traditional liability “fault” type contracts.
 - Hospital, medical, and surgical benefits coverage of Medicare or a governmental plan offered, required, or provided by law, except Medicaid or any other plan whose benefits are by law excess to any private insurance coverage.
3. **“Primary plan”** is one whose benefits must be determined without taking the existence of any other plan into consideration. A plan is primary if either: 1) the plan has no order of benefits rules or its rules differ from those required by regulation; or 2) all plans which cover the person use the order of benefits rules required by regulation and under those rules the plan determines its benefits first. More than one plan may be a primary plan (for example, two plans which have no order of benefit determination rules).
4. **“Secondary plan”** is one which is not a primary plan. If a person is covered by more than one secondary plan, the order of benefit determination rules decide the order in which their benefits are determined in relation to each other.

B. Rules to Determine Order of Payment.

The first of the rules listed below in paragraphs 1-6 that applies will determine which plan will be primary:

1. If the other plan does not have a provision similar to this one, then the other plan will be primary.
2. If the person receiving benefits is the Subscriber and is only covered as a Dependent under the other plan, this Certificate will be primary.
3. If a child is covered under the plans of both parents and the parents are not separated or divorced, the plan of the parent whose birthday falls earlier in the year will be primary. If both parents have the same birthday, the plan which covered the parent longer will be primary. To determine whose birthday falls earlier in the year, only the month and day are considered. However, if the other plan does not have this birthday rule, but instead has a rule based on the sex of the parent and as a result the plans do not agree on which is primary, then the rule in the other plan will determine which plan is primary.
4. If a child is covered by both parents' plans, the parents are separated or divorced, and there is no court decree between the parents that establishes financial responsibility for the child's health care expenses:
 - The plan of the parent who has custody will be primary;
 - If the parent with custody has remarried, and the child is also covered as a child under the step-parent's plan, the plan of the parent with custody will pay first, the step-parent's plan will pay second, and the plan of the parent without custody will pay third; and
 - If a court decree between the parents says which parent is responsible for the child's health care expenses, then that parent's plan will be primary if that plan has actual knowledge of the decree.
5. If the person receiving services is covered under one plan as an active employee or member (i.e., not laid-off or retired), or as the spouse or child of such an active employee, and is also covered under another plan as a laid-off or retired employee or as the spouse or child of such a laid-off or retired employee, the plan that covers such person as an active employee or spouse or child of an active employee will be primary. If the other plan does not have this rule, and as a result the plans do not agree on which will be primary, this rule will be ignored.
6. If none of the above rules determine which plan is primary, the plan that covered the person receiving services longer will be primary.

C. Effects of Coordination.

When this plan is secondary, its benefits will be reduced so that the total benefits paid by the primary plan and this plan during a claim determination period will not exceed Our maximum available benefit for each Covered Service. Also, the amount We pay will

not be more than the amount We would pay if We were primary. As each claim is submitted, We will determine Our obligation to pay for allowable expenses based upon all claims that have been submitted up to that point in time during the claim determination period.

D. Right to Receive and Release Necessary Information.

We may release or receive information that We need to coordinate benefits. We do not need to tell anyone or receive consent to do this. We are not responsible to anyone for releasing or obtaining this information. You must give Us any needed information for coordination purposes, in the time frame requested.

E. Our Right to Recover Overpayment.

If We made a payment as a primary plan, You agree to pay Us any amount by which We should have reduced Our payment. Also, We may recover any overpayment from the primary plan or the Provider receiving payment and You agree to sign all documents necessary to help Us recover any overpayment.

F. Coordination with “Always Excess,” “Always Secondary,” or “Non-Complying” Plans.

Except as described below, We will coordinate benefits with plans, whether insured or self-insured, that provide benefits that are stated to be always excess or always secondary or use order of benefit determination rules that are inconsistent with the rules described above in the following manner:

1. If this Certificate is primary, as defined in this section, We will pay benefits first.
2. If this Certificate is secondary, as defined in this section, We will pay only the amount We would pay as the secondary insurer.
3. If We request information from a non-complying plan and do not receive it within 30 days, We will calculate the amount We should pay on the assumption that the non-complying plan and this Certificate provide identical benefits. When the information is received, We will make any necessary adjustments.

If a blanket accident insurance policy issued in accordance with Section 1015.11 of the General Business Law contains a provision that its benefits are excess or always secondary, then this Certificate is primary.

SECTION XX

Termination of Coverage

Coverage under this Certificate will automatically be terminated on the first of the following to apply:

1. The Group and/or Subscriber has failed to pay Premiums within 30 days of when Premiums are due. Coverage will terminate as of the last day for which Premiums were paid.
2. The end of the month in which the Subscriber ceases to meet the eligibility requirements as defined by the Group.
3. Upon the Subscriber's death, coverage will terminate unless the Subscriber has coverage for Dependents. If the Subscriber has coverage for Dependents, then coverage will terminate as of the last day of the month for which the Premium had been paid.
4. For Spouses in cases of divorce, the date of the divorce.
5. For Children, until the end of the month in which the Child turns 26 years of age.
6. For all other Dependents, the end of the month in which the Dependent ceases to be eligible.
7. The end of the month during which the Group or Subscriber provides written notice to Us requesting termination of coverage, or on such later date requested for such termination by the notice.
8. If the Subscriber or the Subscriber's Dependent has performed an act that constitutes fraud or the Subscriber has made an intentional misrepresentation of material fact in writing on his or her enrollment application, or in order to obtain coverage for a service, coverage will terminate immediately upon written notice of termination delivered by Us to the Subscriber and/or the Subscriber's Dependent, as applicable. However, if the Subscriber makes an intentional misrepresentation of material fact in writing on his or her enrollment application, We will rescind coverage if the facts misrepresented would have led Us to refuse to issue the coverage. Rescission means that the termination of Your coverage will have a retroactive effect of up to Your enrollment under the Certificate. If termination is a result of the Subscriber's action, coverage will terminate for the Subscriber and any Dependents. If termination is a result of the Dependent's action, coverage will terminate for the Dependent.

9. The date that the Group Contract is terminated. If We decide to stop offering a particular class of group contracts, without regard to claims experience or health related status, to which this Certificate belongs, We will provide the Group and Subscribers at least 90 days' prior written notice.
10. If We decide to stop offering all hospital, surgical and medical expense coverage in the large group market in this state, We will provide written notice to the Group and Subscriber at least 180 days prior to when the coverage will cease.
11. The Group has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage.
12. The Group ceases to meet the statutory requirements to be defined as a group for the purposes of obtaining coverage. We will provide written notice to the Group and Subscriber at least 30 days prior to when the coverage will cease.
13. ^[27] The date there is no longer any Subscriber who lives, resides, or works in Our Service Area.]

No termination shall prejudice the right to a claim for benefits which arose prior to such termination.

See the Continuation of Coverage section of this Certificate for Your right to continuation of this coverage. See the Conversion Right to a New Contract after Termination section of this Certificate for Your right to conversion to an individual Contract.

SECTION XXI

Extension of Benefits

When Your coverage under this Certificate ends, benefits stop. But, if You are totally disabled on the date the Group Contract terminates, or on the date Your coverage under this Certificate terminates, continued benefits may be available for the treatment of the injury or sickness that is the cause of the total disability.

For purposes of this section, “total disability” means You are prevented because of injury or disease from engaging in any work or other gainful activity. Total disability for a minor means that the minor is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex who is in good health.

A. When You May Continue Benefits.

When Your coverage under this Certificate ends, We will provide benefits during a period of total disability for a Hospital stay commencing, or surgery performed, within 31 days from the date Your coverage ends. The Hospital stay or surgery must be for the treatment of the injury, sickness, or pregnancy causing the total disability.

If Your coverage ends because You are no longer employed, We will provide benefits during a period of total disability for up to 12 months from the date Your coverage ends for Covered services to treat the injury, sickness, or pregnancy that caused the total disability, unless these services are covered under another group health plan.

B. Termination of Extension of Benefits.

Extended benefits will end on the earliest of the following:

- The date You are no longer totally disabled;
- The date the contractual benefit has been exhausted;
- 12 months from the date extended benefits began (if Your benefits are extended based on termination of employment); or
- With respect to the 12-month extension of coverage, the date You become eligible for benefits under any group policy providing medical benefits.

C. Limits on Extended Benefits.

We will not pay extended benefits:

- For any Member who is not totally disabled on the date coverage under this Certificate ends; or
- Beyond the extent to which We would have paid benefits under this Certificate if coverage had not ended.

SECTION XXII

Continuation of Coverage

Under the continuation of coverage provisions of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), most employer-sponsored group health plans must offer employees and their families the opportunity for a temporary continuation of health insurance coverage when their coverage would otherwise end. If You are not entitled to temporary continuation of coverage under COBRA, You may be entitled to temporary continuation coverage under the New York Insurance Law as described below. Call or write Your employer to find out if You are entitled to temporary continuation of coverage under COBRA or under the New York Insurance Law. Any period of continuation of coverage will terminate automatically at the end of the period of continuation provided under COBRA or the New York Insurance Law.

A. Qualifying Events.

Pursuant to federal COBRA and state continuation coverage laws, You, the Subscriber, Your Spouse and Your Children may be able to temporarily continue coverage under this Certificate in certain situations when You would otherwise lose coverage, known as qualifying events.

1. If Your coverage ends due to voluntary or involuntary termination of employment or a change in Your employee class (e.g., a reduction in the number of hours of employment), You may continue coverage. Coverage may be continued for You, Your Spouse and any of Your covered Children.
2. If You are a covered Spouse, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Divorce or legal separation from the Subscriber; or
 - Death of the Subscriber.
3. If You are a covered Child, You may continue coverage if Your coverage ends due to:
 - Voluntary or involuntary termination of the Subscriber's employment;
 - Reduction in the hours worked by the Subscriber or other change in the Subscriber's class;
 - Loss of covered Child status under the plan rules; or
 - Death of the Subscriber.

If You want to continue coverage, You must request continuation from the Group in writing and make the first Premium payment within the 60-day period following the later of:

1. The date coverage would otherwise terminate; or
2. The date You are sent notice by first class mail of the right of continuation by the Group.

The Group may charge up to 102% of the Group Premium for continued coverage.

Continued coverage under this section will terminate at the earliest of the following:

1. The date 36 months after the Subscriber's coverage would have terminated because of termination of employment;
2. If You are a covered Spouse or Child, the date 36 months after coverage would have terminated due to the death of the Subscriber, divorce or legal separation, the Subscriber's eligibility for Medicare, or the failure to qualify under the definition of "Children";
3. The date You become covered by an insured or uninsured arrangement that provides group hospital, surgical or medical coverage;
4. The date You become entitled to Medicare;
5. The date to which Premiums are paid if You fail to make a timely payment; or
6. The date the Group Contract terminates. However, if the Group Contract is replaced with similar coverage, You have the right to become covered under the new Group Contract for the balance of the period remaining for Your continued coverage.

When Your continuation of coverage ends, You may have a right to conversion. See the Conversion Right to a New Contract after Termination section of this Certificate.

B. Supplementary Continuation, Conversion, and Temporary Suspension Rights During Active Duty.

If You, the Subscriber, are a member of a reserve component of the armed forces of the United States, including the National Guard, You have the right to continuation, conversion, or a temporary suspension of coverage during active duty and reinstatement of coverage at the end of active duty if Your Group does not voluntarily maintain Your coverage and if:

1. Your active duty is extended during a period when the president is authorized to order units of the reserve to active duty, provided that such additional active duty is at the request and for the convenience of the federal government; and
2. You serve no more than four (4) years of active duty.

When Your Group does not voluntarily maintain Your coverage during active duty, coverage under this Certificate will be suspended unless You elect to continue coverage in writing within 60 days of being ordered to active duty and You pay the Group the required Premium payment but not more frequently than on a monthly basis in advance. This right of continuation extends to You and Your eligible Dependents. Continuation of coverage is not available for any person who is eligible to be covered under Medicare; or any person who is covered as an employee, member or dependent under any other insured or uninsured arrangement which provides group hospital, surgical or medical

coverage, except for coverage available to active duty members of the uniformed services and their family members.

Upon completion of active duty:

1. Your coverage under this Certificate may be resumed as long as You are reemployed or restored to participation in the Group upon return to civilian status. The right of resumption extends to coverage for Your covered Dependents. For coverage that was suspended while on active duty, coverage under the Group plan will be retroactive to the date on which active duty terminated.
2. If You are not reemployed or restored to participation in Your Group upon return to civilian status, You will be eligible for continuation and conversion as long as You apply to Us for coverage within 31 days of the termination of active duty or discharge from a Hospitalization resulting from active duty as long as the Hospitalization was not in excess of one (1) year.

C. Availability of Age 29 Dependent Coverage Extension – Young Adult Option.

The Subscriber's Child may be eligible to purchase continuation coverage under the Group's Contract through the age of 29 if he or she:

1. Is under the age of 30;
2. Is not married;
3. Is not insured by or eligible for coverage under an employer-sponsored health benefit plan covering him or her as an employee or member, whether insured or self-insured;
4. Lives, works or resides in New York State or Our Service Area; and
5. Is not covered by Medicare.

The Child may purchase continuation coverage even if he or she is not financially dependent on his or her parent(s) and does not need to live with his or her parent(s).

The Subscriber's Child may elect this coverage:

1. Within 60 days of the date that his or her coverage would otherwise end due to reaching the maximum age for Dependent coverage, in which case coverage will be retroactive to the date that coverage would otherwise have terminated;
2. Within 60 days of newly meeting the eligibility requirements, in which case coverage will be prospective and start within 30 days of when the Group or the Group's designee receives notice and We receive Premium payment; or
3. During an annual 30-day open enrollment period, in which case coverage will be prospective and will start within 30 days of when the Group or the Group's designee receives notice of election and We receive Premium payment.

The Subscriber or Subscriber's Child must pay the Premium rate that applies to individual coverage. Coverage will be the same as the coverage provided under this Certificate. The Child's children are not eligible for coverage under this option.

SECTION XXIII

Conversion Right to a New Contract after Termination

A. Circumstances Giving Rise to Right to Conversion.

You have the right to convert to a new Contract if coverage under this Certificate terminates under the circumstances described below.

- 1. Termination of the Group Contract.** If the Group Contract between Us and the Group is terminated as set forth in the Termination of Coverage section of this Certificate, and the Group has not replaced the coverage with similar and continuous health care coverage, whether insured or self-insured, You are entitled to purchase a new Contract as a direct payment member.
- 2. If You Are No Longer Covered in a Group.** If Your coverage terminates under the Termination of Coverage section of this Certificate because You are no longer a member of a Group, You are entitled to purchase a new Contract as a direct payment member.
- 3. On the Death of the Subscriber.** If coverage terminates under the Termination of Coverage section of this Certificate because of the death of the Subscriber, the Subscriber's Dependents are entitled to purchase a new Contract as direct payment members.
- 4. Termination of Your Marriage.** If a Spouse's coverage terminates under the Termination of Coverage section of this Certificate because the Spouse becomes divorced from the Subscriber or the marriage is annulled, that former Spouse is entitled to purchase a new Contract as a direct payment member.
- 5. Termination of Coverage of a Child.** If a Child's coverage terminates under the Termination of Coverage section of this Certificate because the Child no longer qualifies as a Child, the Child is entitled to purchase a new Contract as a direct payment member.
- 6. Termination of Your Temporary Continuation of Coverage.** If coverage terminates under the Termination of Coverage section of this Certificate because You are no longer eligible for continuation of coverage, You are entitled to purchase a new Contract as a direct payment member.
- 7. Termination of Your Young Adult Coverage.** If a Child's young adult coverage terminates under the Termination of Coverage section of this Certificate, the Child is entitled to purchase a new Contract as a direct payment member.

B. When to Apply for the New Contract.

If You are entitled to purchase a new Contract as described above, You must apply to Us for the new Contract within 60 days after termination of coverage under this Certificate. You must also pay the first Premium of the new Contract at the time You apply for coverage.

C. The New Contract.

We will offer You an individual direct payment Contract at each level of coverage (i.e., bronze, silver, gold or platinum) that Covers all benefits required by state and federal law. You may choose among any of the four (4) Contracts offered by Us. The coverage may not be the same as Your current coverage.

SECTION XXIV

General Provisions

1. **Agreements Between Us and Participating Providers.**

Any agreement between Us and Participating Providers may only be terminated by Us or the Providers. This Certificate does not require any Provider to accept a Member as a patient. We do not guarantee a Member's admission to any Participating Provider or any health benefits program.

2. **Assignment.**

You cannot assign any benefits under this Certificate or legal claims based on a denial of benefits to any person, corporation or other organization. You cannot assign any monies due under this Certificate to any person, corporation or other organization unless it is an assignment to Your Provider for a surprise bill. See the How Your Coverage Works section of this Certificate for more information about surprise bills. Any assignment of benefits or legal claims based on a denial of benefits by You other than for monies due for a surprise bill will be void and unenforceable.

Assignment means the transfer to another person, corporation or other organization of Your right to the services provided under this Certificate or Your right to collect money from Us for those services. Nothing in this paragraph shall affect Your right to appoint a designee or representative as otherwise permitted by applicable law.

3. **Changes in this Certificate.**

We may unilaterally change this Certificate upon renewal, if We give the Group 30 days' prior written notice.

4. **Choice of Law.**

This Certificate shall be governed by the laws of the State of New York.

5. **Clerical Error.**

Clerical error, whether by the Group or Us, with respect to this Certificate, or any other documentation issued by Us in connection with this Certificate, or in keeping any record pertaining to the coverage hereunder, will not modify or invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

6. **Conformity with Law.**

Any term of this Certificate which conflicts with New York State law or with any applicable federal law that imposes additional requirements from what is required under New York State law will be amended to conform with the minimum requirements of such law.

7. **Continuation of Benefit Limitations.**

Some of the benefits in this Certificate may be limited to a specific number of visits, and/or subject to a Deductible. You will not be entitled to any additional benefits if Your coverage status should change during the year. For example, if Your coverage status changes from covered family member to Subscriber, all benefits previously utilized when You were a covered family member will be applied toward Your new status as a Subscriber.

8. Enrollment ERISA.

The Group will develop and maintain complete and accurate payroll records, as well as any other records of the names, addresses, ages, and social security numbers of all Group Members covered under this Certificate, and any other information required to confirm their eligibility for coverage.

The Group will provide Us with this information upon request. The Group may also have additional responsibilities as the “plan administrator” as defined by the Employee Retirement Income Security Act of 1974 (“ERISA”), as amended. The “plan administrator” is the Group, or a third party appointed by the Group. We are not the ERISA plan administrator.

9. Entire Agreement.

This Certificate, including any endorsements, riders and the attached applications, if any, constitutes the entire Certificate.

10. Fraud and Abusive Billing.

We have processes to review claims before and after payment to detect fraud and abusive billing. Members seeking services from Non-Participating Providers could be balance billed by the Non-Participating Provider for those services that are determined to be not payable as a result of a reasonable belief of fraud or other intentional misconduct or abusive billing.

11. Furnishing Information and Audit.

The Group and all persons covered under this Certificate will promptly furnish Us with all information and records that We may require from time to time to perform Our obligations under this Certificate. You must provide Us with information over the telephone for reasons such as the following: to allow Us to determine the level of care You need; so that We may certify care authorized by Your Physician; or to make decisions regarding the Medical Necessity of Your care. The Group will, upon reasonable notice, make available to Us, and We may audit and make copies of, any and all records relating to Group enrollment at the Group’s New York office.

12. Identification Cards.

Identification (“ID”) cards are issued by Us for identification purposes only. Possession of any ID card confers no right to services or benefits under this Certificate. To be entitled to such services or benefits, Your Premiums must be paid in full at the time the services are sought to be received.

13. Incontestability.

No statement made by You will be the basis for avoiding or reducing coverage unless it is in writing and signed by You. All statements contained in any such written instrument shall be deemed representations and not warranties.

14. Independent Contractors.

Participating Providers are independent contractors. They are not Our agents or employees. We and Our employees are not the agent or employee of any Participating Provider. We are not liable for any claim or demand on account of damages arising out of, or in any manner connected with, any injuries alleged to be suffered by You, Your covered Spouse or Children while receiving care from any Participating Provider or in any Participating Provider's Facility.

15. Input in Developing Our Policies.

Subscribers may participate in the development of Our policies by forwarding your suggestions or ideas to our Member Mailbox; Attn: CDPHP Member Services Department, 500 Patroon Creek Boulevard, Albany, NY 12206-1057.

16. Material Accessibility.

We will give the Group, and the Group will give You ID cards, Certificates, riders and other necessary materials.

17. More Information about Your Health Plan.

You can request additional information about Your coverage under this Certificate. Upon Your request, We will provide the following information:

- A list of the names, business addresses and official positions of Our board of directors, officers and members; and Our most recent annual certified financial statement which includes a balance sheet and a summary of the receipts and disbursements.
- The information that We provide the State regarding Our consumer complaints.
- A copy of Our procedures for maintaining confidentiality of Member information.
- A copy of Our drug formulary. You may also inquire if a specific drug is Covered under this Certificate.
- A written description of Our quality assurance program.
- A copy of Our medical policy regarding an experimental or investigational drug, medical device or treatment in clinical trials.
- Provider affiliations with participating Hospitals.
- A copy of Our clinical review criteria (e.g., Medical Necessity criteria), and where appropriate, other clinical information We may consider regarding a specific disease, course of treatment or Utilization Review guidelines, including clinical review criteria relating to a step therapy protocol override determination.
- Written application procedures and minimum qualification requirements for Providers.

- Documents that contain the processes, strategies, evidentiary standards, and other factors used to apply a treatment limitation with respect to medical/surgical benefits and mental health or substance use disorder benefits under the Certificate.

18. Notice.

Any notice that We give You under this Certificate will be mailed to Your address as it appears in Our records or delivered electronically if You consent to electronic delivery or to the address of the Group. If notice is delivered to You electronically, You may also request a copy of the notice from Us. You agree to provide Us with notice of any change of Your address. If You have to give Us any notice, it should be sent by U.S. mail, first class, postage prepaid to: the address on Your ID card.

19. Premium Refund.

We will give any refund of Premiums, if due, to the Group.

20. Recovery of Overpayments.

On occasion, a payment may be made to You when You are not covered, for a service that is not Covered, or which is more than is proper. When this happens, We will explain the problem to You and You must return the amount of the overpayment to Us within 60 days after receiving notification from Us. However, We shall not initiate overpayment recovery efforts more than 24 months after the original payment was made unless We have a reasonable belief of fraud or other intentional misconduct.

21. Renewal Date.

The renewal date for this Certificate is the anniversary of the effective date of the Group Contract of each year. This Certificate will automatically renew each year on the renewal date, unless otherwise terminated by Us as permitted by this Certificate or by the Group upon 30 days' prior written notice to Us.

22. Reinstatement after Default.

If the Subscriber defaults in making any payment under this Contract, the subsequent acceptance of payment by Us or by one of Our authorized agents or brokers shall reinstate the Contract.

23. Right to Develop Guidelines and Administrative Rules.

We may develop or adopt standards that describe in more detail when We will or will not make payments under this Certificate. Examples of the use of the standards are to determine whether: Hospital inpatient care was Medically Necessary; surgery was Medically Necessary to treat Your illness or injury; or certain services are skilled care. Those standards will not be contrary to the descriptions in this Certificate. If You have a question about the standards that apply to a particular benefit, You may contact Us and We will explain the standards or send You a copy of the standards. We may also develop administrative rules pertaining to enrollment and other administrative matters.

We shall have all the powers necessary or appropriate to enable Us to carry out Our duties in connection with the administration of this Certificate.

We review and evaluate new technology according to technology evaluation criteria developed by Our medical directors and reviewed by a designated committee, which consists of Health Care Professionals from various medical specialties. Conclusions of the committee are incorporated into Our medical policies to establish decision protocols for determining whether a service is Medically Necessary, experimental or investigational, or included as a Covered benefit.

24. Right to Offset.

If We make a claim payment to You or on Your behalf in error or You owe Us any money, You must repay the amount You owe Us. Except as otherwise required by law, if We owe You a payment for other claims received, We have the right to subtract any amount You owe Us from any payment We owe You.

25. Severability.

The unenforceability or invalidity of any provision of this Certificate shall not affect the validity and enforceability of the remainder of this Certificate.

26. Significant Change in Circumstances.

If We are unable to arrange for Covered Services as provided under this Certificate as the result of events outside of Our control, We will make a good faith effort to make alternative arrangements. These events would include a major disaster, epidemic, the complete or partial destruction of facilities, riot, civil insurrection, disability of a significant part of Participating Providers' personnel, or similar causes. We will make reasonable attempts to arrange for Covered Services. We and Our Participating Providers will not be liable for delay, or failure to provide or arrange for Covered Services if such failure or delay is caused by such an event.

27. Subrogation and Reimbursement.

These paragraphs apply when another party (including any insurer) is, or may be found to be, responsible for Your injury, illness or other condition and We have provided benefits related to that injury, illness or condition. As permitted by applicable state law, unless preempted by federal law, We may be subrogated to all rights of recovery against any such party (including Your own insurance carrier) for the benefits We have provided to You under this Certificate. Subrogation means that We have the right, independently of You, to proceed directly against the other party to recover the benefits that We have provided.

Subject to applicable state law, unless preempted by federal law, We may have a right of reimbursement if You or anyone on Your behalf receives payment from any responsible party (including Your own insurance carrier) from any settlement, verdict or insurance proceeds, in connection with an injury, illness, or condition for which We provided benefits. Under New York General Obligations Law Section 5-335, Our right of

recovery does not apply when a settlement is reached between a plaintiff and defendant, unless a statutory right of reimbursement exists. The law also provides that, when entering into a settlement, it is presumed that You did not take any action against Our rights or violate any contract between You and Us. The law presumes that the settlement between You and the responsible party does not include compensation for the cost of health care services for which We provided benefits.

We request that You notify Us within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of Your intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness or condition sustained by You for which We have provided benefits. You must provide all information requested by Us or Our representatives including, but not limited to, completing and submitting any applications or other forms or statements as We may reasonably request.

28. Third Party Beneficiaries.

No third party beneficiaries are intended to be created by this Certificate and nothing in this Certificate shall confer upon any person or entity other than You or Us any right, benefit, or remedy of any nature whatsoever under or by reason of this Certificate. No other party can enforce this Certificate's provisions or seek any remedy arising out of either Our or Your performance or failure to perform any portion of this Certificate, or to bring an action or pursuit for the breach of any terms of this Certificate.

29. Time to Sue.

No action at law or in equity may be maintained against Us prior to the expiration of 60 days after written submission of a claim has been furnished to Us as required in this Certificate. You must start any lawsuit against Us under this Certificate within two (2) years from the date the claim was required to be filed.

30. Translation Services.

Translation services are available free of charge under this Certificate for non-English speaking Members. Please contact Us at the number on Your ID card to access these services.

31. Venue for Legal Action.

If a dispute arises under this Certificate, it must be resolved in a court located in the State of New York. You agree not to start a lawsuit against Us in a court anywhere else. You also consent to New York State courts having personal jurisdiction over You. That means that, when the proper procedures for starting a lawsuit in these courts have been followed, the courts can order You to defend any action We bring against You.

32. Waiver.

The waiver by any party of any breach of any provision of this Certificate will not be construed as a waiver of any subsequent breach of the same or any other provision. The failure to exercise any right hereunder will not operate as a waiver of such right.

33. Who May Change this Certificate.

This Certificate may not be modified, amended, or changed, except in writing and signed by Our Chief Executive Officer (“CEO”) or a person designated by the CEO. No employee, agent, or other person is authorized to interpret, amend, modify, or otherwise change this Certificate in a manner that expands or limits the scope of coverage, or the conditions of eligibility, enrollment, or participation, unless in writing and signed by the CEO or person designated by the CEO.

34. Who Receives Payment under this Certificate.

Payments under this Certificate for services provided by a Participating Provider will be made directly by Us to the Provider. If You receive services from a Non-Participating Provider, We reserve the right to pay either You or the Provider. If You assign benefits for a surprise bill to a Non-Participating Provider, We will pay the Non-Participating Provider directly. See the How Your Coverage Works section of this Certificate for more information about surprise bills.

35. Workers’ Compensation Not Affected.

The coverage provided under this Certificate is not in lieu of and does not affect any requirements for coverage by workers’ compensation insurance or law.

36. Your Medical Records and Reports.

In order to provide Your coverage under this Certificate, it may be necessary for Us to obtain Your medical records and information from Providers who treated You. Our actions to provide that coverage include processing Your claims, reviewing Grievances, Appeals or complaints involving Your care, and quality assurance reviews of Your care, whether based on a specific complaint or a routine audit of randomly selected cases. By accepting coverage under this Certificate except as prohibited by state or federal law, You automatically give Us or Our designee permission to obtain and use Your medical records for those purposes and You authorize each and every Provider who renders services to You to:

- Disclose all facts pertaining to Your care, treatment, and physical condition to Us or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim, or in connection with a complaint or quality of care review;
- Render reports pertaining to Your care, treatment, and physical condition to Us, or to a medical, dental, or mental health professional that We may engage to assist Us in reviewing a treatment or claim; and
- Permit copying of Your medical records by Us.

We agree to maintain Your medical information in accordance with state and federal confidentiality requirements. However, to the extent permitted under state or federal law, You automatically give Us permission to share Your information with the New York State Department of Health, quality oversight organizations, and third parties with which We contract to assist Us in administering this Certificate, so long as they also agree to

maintain the information in accordance with state and federal confidentiality requirements.

37. Your Rights.

You have the right to obtain complete and current information concerning a diagnosis, treatment and prognosis from a Physician or other Provider in terms You can reasonably understand. When it is not advisable to give such information to You, the information shall be made available to an appropriate person acting on Your behalf.

You have the right to receive information from Your Physician or other Provider that You need in order to give Your informed consent prior to the start of any procedure or treatment.

You have the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of that action.

You have the right to formulate advance directives regarding Your care.

As a Member, You should also take an active role in Your care. We encourage You to:

- Inform Us if You have any changes to Your name, address or Dependents covered under Your Certificate.

If You need more information or would like to contact Us, please go to Our website at www.cdphp.com call Us at the number on Your ID card.

Section XXV

Other Covered Services

Lasik Reimbursement

CDPHP will reimburse up to seven hundred and fifty dollars (\$750) for elective refractive eye surgery, including Lasik (Laser-assisted in-situ keratomileusis) when performed solely to eliminate the need for glasses or contact lenses. CDPHP will provide reimbursement up to seven hundred and fifty dollars (\$750) for elective refractive eye surgery per Member, per Lifetime to include pre-consultation and post-consultation visits. Receipt of payment for eligible services can be submitted by You to CDPHP for reimbursement.

[²⁸ Preventive Prescription drugs

Preventive Prescription drugs as defined by the Capital District Physicians' Health Plan formulary are not subject to the plan Deductible. They are subject only to the Coinsurance or Copayment listed in the Schedule of Benefits of your member.]

[²⁹ Additional Preventive Services

Additional preventive services, as defined by the Capital District Physicians' Health Plan, are not subject to the plan Deductible. They are subject only to the Coinsurance or Copayment listed in the Schedule of Benefits of your Member Certificate.”]

Out of Service Area Benefit for Covered Student Dependents

Full-Time Student Dependent: A full-time student in a degree program at a postsecondary educational institution as found in Section 102 of the Higher Education Act of 1965; or, a full-time student participating in an extended course of study at a registered or licensed business or trade school leading to eligibility for licensure or certification in a vocation or technical field.

In addition to the Medically Necessary services Covered under the Certificate, when a Covered student Dependent is attending school outside of CDPHP's Service Area, CDPHP will provide additional Coverage for the following:

- i. Medically Necessary services rendered outside the CDPHP Service Area, subject to the prior approval requirement stated below.
- ii. Coverage outside of the Service Area does not apply during vacations and/or summer

recess. If a student Dependent is enrolled in classes required toward their elected course of study during periods usually deemed to be vacation and/or summer recess, Coverage outside of the Service Area as described above will remain in effect.

iii. Preventive Care rendered outside the Service Area which is not for the purpose of treating a particular illness, injury or disease is excluded. Preventive Care will be Covered under the Certificate only when it is provided or arranged by the Member's Primary Care Physician in the Service Area.

iv. Out of area coverage for student Dependents is not limited to students age 19 and older, as long as the other requirements stated in this section are met.

Prior Approval Requirement for Out of Service Area Coverage

i. Except for Emergency care as provided by the Certificate, prior approval must be obtained before services rendered to student Dependents out of the Service Area under this Contract

ii. If a student Dependent has an illness, injury or disease which

a. Results in absence from classes for more than two consecutive school weeks or;

b. Requires continued medical treatment for more than 60 days, then CDPHP reserves the right to require the student Dependent to return to CDPHP's Service Area to obtain Medically Necessary services from Participating Providers.



SECTION XXVI

CDPHP HMO SCHEDULE OF BENEFITS

COST-SHARING	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
<p>Deductible</p> <ul style="list-style-type: none"> • Individual • Family 	<p>[None; N/A] [None; N/A]</p>	<p>[³⁰ None; \$0; \$1,000; \$1,250; \$1,350; \$1,400; \$1,500; \$2,700; \$3,000] [³¹ None; \$0; \$2,500; \$2,700; \$2,800; \$3,000; \$5,400; \$7,500]</p>	<p>Non-Participating Provider services are not Covered except as required for emergency care and Urgent Care.</p>	<p>[The Deductible listed for Preferred Providers and Participating Providers are combined and not two separate amounts.]</p>
<p>Out-of-Pocket Limit</p> <ul style="list-style-type: none"> • Individual • Family 	<p>N/A N/A</p>	<p>[³² \$2,400; \$2,500; \$3,000; \$5,000; \$6,850; \$8,550] [³³ \$4,800; \$6,000; \$6,250; \$10,000; \$13,700; \$17,100]</p>		<p>The Out-of-Pocket Limit listed for Preferred</p>

				Providers and Participating Providers are combined and not two separate amounts.
OFFICE VISITS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Primary Care Office Visits (or Home Visits)	[³⁴ N/A; Covered in Full]	[³⁵ \$10; \$15; \$20; \$25; \$30] Copayment [³⁶ [after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Specialist Office Visits (or Home Visits)	N/A	[³⁷ \$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment [³⁸ [after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description Walk-in visits at preferred providers for

<p>Preauthorization required for Sleep Studies, Neurofeedback & Transcranial Magnetic Stimulation (TMS)</p>				<p>Chronic Heart Failure diagnoses are subject to \$0 cost sharing.</p>
<p>PREVENTIVE CARE</p>	<p>Preferred Provider Member Responsibility for Cost-Sharing</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<ul style="list-style-type: none"> • Well Child Visits and Immunizations* • Adult Annual Physical Examinations* • Adult Immunizations* 	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>[⁴¹ Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[⁴² Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[⁴³ Covered in full; Use</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> • Routine Gynecological Services/Well Woman Exams* • Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer • [³⁹ Sterilization Procedures for Women*] 	<p>N/A</p> <p>Covered in full</p> <p>N/A</p>	<p>Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[⁴⁴ Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>Covered in full</p> <p>[⁴⁵ Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office</p>	<p>Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost]</p>	
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<ul style="list-style-type: none"> • ^[40] Vasectomy 	<p>N/A</p>	<p>Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing; Ambulatory Surgical Center Facility; Outpatient Hospital Surgery Facility)]</p> <p>Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost]</p>	
<ul style="list-style-type: none"> • Bone Density Testing* 	<p>N/A</p>	<p>^[46] Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<ul style="list-style-type: none"> • Screening for Prostate Cancer 	<p>N/A</p>	<p>^[47] Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	

<ul style="list-style-type: none"> All other preventive services required by USPSTF and HRSA <ul style="list-style-type: none"> *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA <p>Preauthorization required for Genetic Testing and Immunizations for Respiratory Syncytial Virus</p>	<p>N/A</p> <p>N/A</p>	<p>Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>[⁴⁸ Covered in full; Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)]</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
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EMERGENCY CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Pre-Hospital Emergency Medical Services (Ambulance Services)	N/A	[⁴⁹ \$50; \$75; \$100] Copayment] [⁵⁰ 20%] Coinsurance] [[after; not subject to] Deductible]	[\$50; \$75; \$100] Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	See benefit for description
Non-Emergency Ambulance Services Preauthorization required	N/A	[⁵¹ \$50; \$75; \$100] Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Emergency Department Copayment / Coinsurance waived if admitted to Hospital	N/A	[⁵² \$50; \$75; \$100] Copayment] [⁵³ 20%] Coinsurance] [[after; not subject to] Deductible] Health care forensic examinations performed under Public Health Law § 2805-i are not subject to [⁵⁴ Cost-Sharing; [Copayment or Coinsurance]	[\$50; \$75; \$100] Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	See benefit for description
Urgent Care Center	N/A	[⁵⁵ \$20; \$25; \$30; \$35; \$40; \$50; \$60]	[⁵⁶ \$20; \$25; \$30; \$35; \$40; \$50; \$60]	See benefit for

		Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	description
PROFESSIONAL SERVICES and OUTPATIENT CARE	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
Acupuncture	N/A	[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description Limited to 10 visits per Plan Year
Advanced Imaging Services <ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>[⁵⁷ N/A; Covered in Full] [after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [after; not subject to] Deductible]</p>	<p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description

		Deductible]		
<p>Allergy Testing and Treatment</p> <p>Administration</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office <p>Allergy Testing and Treatment Medication</p>	<p>[N/A; Covered in Full]</p> <p>N/A</p> <p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment [[after; not subject to] Deductible]</p> <p>[Covered in full] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Ambulatory Surgical Center Facility Fee</p> <p>Preauthorization required for Sleep Studies</p>	<p>[⁵⁸ \$50; \$100; \$150; \$200 Copayment] [[after; not subject to] Deductible] [N/A]</p>	<p>[⁵⁹ \$0; \$10; \$15; \$20; \$25; \$30; \$40; \$50; \$75; \$100; \$150; \$200; \$250] Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Anesthesia Services (all settings)</p>	<p>N/A</p>	<p>Cost-Sharing included as part of associated service</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>Autologous Blood Banking</p> <p>Preauthorization required</p>	<p>N/A</p>	<p>Cost-Sharing included as part of associated service</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Cardiac and Pulmonary Rehabilitation</p> <ul style="list-style-type: none"> • Performed in a Specialist Office • Performed as Outpatient Hospital Services • Performed as Inpatient Hospital Services 	<p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>[\$0; \$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment [[after; not subject to] Deductible]</p> <p>[\$0; \$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment [[after; not subject to] Deductible]</p> <p>Included as part of inpatient Hospital service Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Chemotherapy and Immunotherapy</p> <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in a Specialist Office 	<p>[N/A; Covered in Full]</p> <p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services Performed at Home 	<p>N/A</p> <p>N/A</p>	<p>Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p>	<p>the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Chiropractic Services</p>	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Clinical Trials</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>Use Cost-Sharing for appropriate service</p>	<p>See benefit for description</p>
<p>Diagnostic Testing</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	<p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p>	<p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Dialysis</p> <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office Performed in a Freestanding Center Performed as Outpatient Hospital Services Performed at Home 	<p>[N/A; Covered in Full]</p> <p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p>	<p>See benefit for description</p> <p>There are no visit limits for Dialysis treatments .</p> <p>Dialysis treatment by a Non-Participating Provider requires Preauthorization.</p>

Home Health Care	N/A	[Covered in full] [\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	There are no visit limits for Home Health Care
Infertility Services Preauthorization required	N/A	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Infusion Therapy <ul style="list-style-type: none"> • Performed in a PCP Office • Performed in Specialist Office • Performed as Outpatient Hospital Services • Home Infusion Therapy 	[N/A; Covered in Full] N/A N/A N/A	[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible] [\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible] [\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible] [\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Preauthorization required				
Inpatient Medical Visits	N/A	Included as part of inpatient Hospital service Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
^[60] Interruption of Pregnancy <ul style="list-style-type: none"> Medically Necessary Abortions Elective Abortions 	<p>N/A</p> <p>N/A</p>	<p>Covered in full [not subject to Deductible]</p> <p>Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	Unlimited
Laboratory Procedures <ul style="list-style-type: none"> Performed in a PCP Office Performed in a Specialist Office 	<p>[N/A; Covered in Full] [after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [after; not subject to] Deductible]</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	See benefit for description

<ul style="list-style-type: none"> Performed in a Freestanding Laboratory Facility Performed as Outpatient Hospital Services <p>Preauthorization required for Genetic Testing</p>	<p>[N/A; Covered in Full] [after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [after; not subject to] Deductible]</p>	<p>[\$0; \$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Maternity and Newborn Care</p> <ul style="list-style-type: none"> Prenatal Care <ul style="list-style-type: none"> Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by 	<p>N/A</p> <p>N/A</p>	<p>Covered in full</p> <p>Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services;</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>USPSTF and HRSA</p> <ul style="list-style-type: none"> Inpatient Hospital Services and Birthing Center Physician and Midwife Services for Delivery Breastfeeding Support, Counseling and Supplies, Including Breast Pumps Postnatal Care 	<p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Laboratory Procedures and Diagnostic Testing)</p> <p>[⁶¹ \$0; \$50; \$100; \$240; \$500; \$1,000] Copayment] [20%] Coinsurance] per admission [[after; not subject to] Deductible]</p> <p>Included as part of the Inpatient Hospital Cost-Sharing</p> <p>Covered in full</p> <p>Covered in full</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>One (1) home care visit is Covered at no Cost-Sharing if mother is discharged from Hospital early</p> <p>Covered for duration of breast feeding</p>
<p>Outpatient Hospital Surgery Facility Charge</p>	<p>N/A</p>	<p>[⁶² \$0; \$10; \$15; \$20; \$25; \$30; \$40; \$50; \$75; \$100; \$150; \$200; \$250]</p>	<p>Non-Participating Provider services are not Covered and You pay</p>	<p>See benefit for description</p>

Preauthorization required for Sleep Studies		Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]	the full cost	
Preadmission Testing	N/A	[\$0 Copayment] [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Prescription Drugs Administered in Office or Outpatient Facilities <ul style="list-style-type: none"> Performed in a PCP Office Performed in Specialist Office Performed in Outpatient Facilities 	N/A N/A N/A	Included as part of the PCP office visit Cost-Sharing Included as part of the Specialist office visit Cost-Sharing Refer to PCP office visit Cost-Sharing	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diagnostic Radiology Services <ul style="list-style-type: none"> Performed in a PCP Office 	[N/A; Covered in Full] [[after; not subject to]	[\$10; \$15; \$20; \$25; \$30] Copayment]	Non-Participating Provider services are not	See benefit for description

<ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility Performed as Outpatient Hospital Services 	<p>Deductible]</p> <p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p> <p>[N/A; Covered in Full] [[after; not subject to] Deductible]</p>	<p>[[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment] [[after; not subject to] Deductible]</p>	<p>Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Therapeutic Radiology Services</p> <ul style="list-style-type: none"> Performed in a Specialist Office Performed in a Freestanding Radiology Facility 	<p>N/A</p> <p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment] [after; not subject to Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment] [after; not subject to Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<ul style="list-style-type: none"> Performed as Outpatient Hospital Services 	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [after; not subject to Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	
<p>Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)</p> <p>Preauthorization required for Speech Therapy beyond first visit for Members through the end of the month in which the Member turns 19 years of age.</p>	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [after; not subject to Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Physical Therapy is limited to [63 30; 120] visits per Plan Year. Occupational Therapy is limited to [64 30; 120] visits per Plan Year. Speech Therapy is limited to [65 20; 60] visits per Plan Year.</p>
<p>Second Opinions on the Diagnosis of Cancer, Surgery and Other</p> <p>Preauthorization required</p>	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30; \$40; \$50] Copayment [[after; not subject to] Deductible]</p>	<p>Second opinions on diagnosis of cancer are Covered at participating Cost-Sharing for non-participating Specialist when a Referral is obtained.</p>	<p>See benefit for description</p>

<p>Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants)</p> <ul style="list-style-type: none"> • Inpatient Hospital Surgery • Outpatient Hospital Surgery • Surgery Performed at an Ambulatory Surgical Center • Office Surgery <p>Preauthorization required</p>	<p>N/A</p> <p>N/A</p> <p>N/A</p> <p>N/A</p>	<p>Included as part of inpatient Hospital service Cost-Sharing</p> <p>Included as part of Outpatient Hospital Surgery Facility Cost-Sharing</p> <p>Included as part of Ambulatory Surgical Center service Cost-Sharing</p> <p>Included as part of Office Visit Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p> <p>All transplants must be performed at designated Facilities</p>
<p>Telemedicine Program</p>	<p>N/A</p>	<p>Use Cost-Sharing for Primary Care Office Visit</p>	<p>Non-Participating Provider services are not Covered and You pay</p>	<p>See benefit for description</p>

ADDITIONAL SERVICES, EQUIPMENT and DEVICES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
ABA Treatment for Autism Spectrum Disorder	N/A	[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder Preauthorization required	N/A	[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
Diabetic Equipment, Supplies and Self-Management Education <ul style="list-style-type: none"> • Diabetic Equipment, Supplies and Insulin (30-day supply) • Diabetic Education 	N/A N/A	[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible] [\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description Out-of-pocket costs for prescription insulin drugs shall not exceed \$100 per 30-day supply, regardless of

				the amount or type of insulin that is needed.
Durable Medical Equipment and Braces Preauthorization required	N/A	[⁶⁶ 50%] Coinsurance [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description
External Hearing Aids	[N/A] [\$599 minimum Copayment, not to exceed \$899] [after; not subject to] Deductible]	[N/A] [20%; 50% Coinsurance] [after; not subject to] Deductible]	[N/A] [Non-Participating Provider services are not Covered and You pay the full cost]	[⁶⁷ Single purchase once every three (3) years] For discounts, contact Hearing Care Solutions at (855) 460-5422 or https://hearingcaresolutions.com/cdphp
Cochlear Implants	N/A	[50%] Coinsurance [[after; not subject to] Deductible]	Non-Participating Provider services are not Covered and You pay the full cost	One (1) per ear per time Covered

<p>Hospice Care</p> <ul style="list-style-type: none"> Inpatient Outpatient 	<p>N/A</p> <p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment</p> <p>[20%] Coinsurance per admission</p> <p>[[after; not subject to] Deductible]</p> <p>[\$10; \$15; \$20; \$25; \$30] Copayment</p> <p>[[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>210 days per Plan Year</p> <p>Five (5) visits for family bereavement counseling</p>
<p>Medical Supplies</p>	<p>N/A</p>	<p>[50%] Coinsurance</p> <p>[[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Prosthetic Devices</p> <ul style="list-style-type: none"> External Internal <p>Preauthorization required</p>	<p>N/A</p> <p>N/A</p>	<p>[50%] Coinsurance</p> <p>[[after; not subject to] Deductible]</p> <p>Included as part of inpatient Hospital Cost-Sharing</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p> <p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Unlimited; See benefit for description</p>

INPATIENT SERVICES and FACILITIES	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	Limits
<p>Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care)</p>	<p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment] [20%] Coinsurance] [per admission] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description [⁶⁸Copayments are limited to two for Individual and three for Family per Plan Year. After the Copayment limit has been satisfied, Covered inpatient services are Covered in Full]</p>
<p>Observation Stay</p>	<p>N/A</p>	<p>[⁶⁹ \$50; \$75; \$100] Copayment] [20%] Coinsurance] [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation)</p> <p>Preauthorization required</p>	<p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment] [20%] Coinsurance] per admission [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>[⁷⁰ 45; 90] days per Plan Year]</p>
<p>Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy)</p> <p>Preauthorization required</p>	<p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment] [20%] Coinsurance] per admission [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>60 days per Plan Year combined therapies</p>
<p>MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES</p>	<p>Preferred Provider Member Responsibility for Cost-Sharing</p>	<p>Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Non-Participating Provider Member Responsibility for Cost-Sharing</p>	<p>Limits</p>
<p>Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization required for Residential Treatment. However, Preauthorization is not</p>	<p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment] [20%] Coinsurance] per admission [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>

<p>required for emergency admissions or for admissions at Participating OMH-licensed Facilities for Members under 18.</p>				
<p>Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)</p>	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment)</p> <p>Preauthorization required for Residential Treatment. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.</p>	<p>N/A</p>	<p>[\$0; \$50; \$100; \$240; \$500; \$1,000] Copayment [20%] Coinsurance per admission [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Outpatient Substance Use Services (including Partial Hospitalization, Intensive</p>	<p>N/A</p>	<p>[\$10; \$15; \$20; \$25; \$30] Copayment [[after; not subject to] Deductible]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>Unlimited; Up to 20 visits per Plan Year</p>

Outpatient Program Services, and Medication Assisted Treatment)				may be used for family counseling
WELLNESS BENEFITS	Preferred Provider Member Responsibility for Cost-Sharing	Participating Provider Member Responsibility for Cost-Sharing	Non-Participating Provider Member Responsibility for Cost-Sharing	
Gym Reimbursement	Not applicable	Not applicable	Not applicable	Participation information and Preauthorization requirements can be easily accessed through Our member site at www.cdphp.com .
[Wellness Program]	Not applicable	Not applicable	Not applicable	Additional rewards available for engaging in designated wellness activities as defined in the

				Wellness section of this Certificate
National Diabetes Prevention Program Reimbursement	Not applicable	Not applicable	Not applicable	The Subscriber, and each covered Dependent can participate in the Diabetes Prevention Program
[Weight Loss Program Reimbursement]	Not applicable	Not applicable	Not applicable	Reimbursement up to a maximum of \$75 per Member, per Plan Year.
[Medical Condition Fitness Program]	Not applicable	Not applicable	Not applicable	Participation information and Preauthorization requirements can be

				easily accessed through Our member site at www.cdphp.com .
[Condition Specific Health and Wellness Program]	Not applicable	Not applicable	Not applicable	Participation information and Preauthorization requirements can be easily accessed through Our member site at www.cdphp.com .
[Maternity Health Wellness Program]	Not applicable	Not applicable	Not applicable	Participation information and Preauthorization requirement

				s can be easily accessed through Our member site at www.cdphp.com .
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All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the Certificate, You will be responsible for the full cost of the services.

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.
500 Patroon Creek Boulevard
Albany, NY 12206-1057

Prescription Drug Coverage Rider

Please refer to the Schedule of Benefits section of this Rider for Cost-Sharing requirements, day or visit limits, and any Preauthorization or Referral requirements that apply to these benefits.

A. Covered Prescription Drugs.

We Cover Medically Necessary Prescription Drugs that, except as specifically provided otherwise, can be dispensed only pursuant to a prescription and are:

- Required by law to bear the legend "Caution – Federal Law prohibits dispensing without a prescription";
- FDA approved;
- Ordered by a Provider authorized to prescribe and within the Provider's scope of practice;
- Prescribed within the approved FDA administration and dosing guidelines;
- On Our Formulary; and
- Dispensed by a licensed pharmacy.

Covered Prescription Drugs include, but are not limited to:

- Self-injectable/administered Prescription Drugs.
- Inhalers (with spacers).
- Topical dental preparations.
- Pre-natal vitamins, vitamins with fluoride, and single entity vitamins.
- Osteoporosis drugs and devices approved by the FDA, or generic equivalents as approved substitutes, for the treatment of osteoporosis and consistent with the criteria of the federal Medicare program or the National Institutes of Health.
- Nutritional formulas for the treatment of phenylketonuria, branched-chain ketonuria, galactosemia and homocystinuria.
- Prescription or non-prescription enteral formulas for home use, whether administered orally or via tube feeding, for which a Physician or other licensed Provider has issued a written order. The written order must state that the enteral formula is Medically Necessary and has been proven effective as a disease-specific treatment regimen. Specific diseases and disorders include but are not limited to: inherited diseases of amino acid or organic acid metabolism; Crohn's disease; gastroesophageal reflux; gastroesophageal motility such as chronic intestinal pseudo-obstruction; and multiple severe food allergies. Multiple food allergies include, but are not limited to: immunoglobulin E and nonimmunoglobulin E-mediated allergies to multiple food proteins; severe food protein induced enterocolitis syndrome; eosinophilic disorders and impaired absorption of nutrients caused by disorders affecting the absorptive surface, function, length, and motility of the gastrointestinal tract.

- Modified solid food products that are low in protein, contain modified protein, or are amino acid based to treat certain inherited diseases of amino acid and organic acid metabolism and severe protein allergic conditions.
- Prescription Drugs prescribed in conjunction with treatment or services Covered under the infertility treatment benefit, including in vitro fertilization, in the Outpatient and Professional Services section of Your Certificate.
- Off-label cancer drugs, so long as the Prescription Drug is recognized for the treatment of the specific type of cancer for which it has been prescribed in one (1) of the following reference compendia: the American Hospital Formulary Service-Drug Information; National Comprehensive Cancer Networks Drugs and Biologics Compendium; Thomson Micromedex DrugDex; Elsevier Gold Standard's Clinical Pharmacology; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services or the Centers for Medicare and Medicaid Services; or recommended by review article or editorial comment in a major peer reviewed professional journal.
- Orally administered anticancer medication used to kill or slow the growth of cancerous cells.
- Smoking cessation drugs, including over-the-counter drugs for which there is a written order and Prescription Drugs prescribed by a Provider.
- Preventive Prescription Drugs, including over-the-counter drugs for which there is a written order, provided in accordance with the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA") or that have an "A" or "B" rating from the United States Preventive Services Task Force ("USPSTF").
- Prescription Drugs for the treatment of mental health and substance use disorders, including drugs for detoxification, maintenance and overdose reversal.
- [1 Contraceptive drugs, devices and other products, including over-the-counter contraceptive drugs, devices and other products, approved by the FDA and as prescribed or otherwise authorized under State or Federal law. "Over-the-counter contraceptive products" means those products provided for in comprehensive guidelines supported by HRSA. Coverage also includes emergency contraception when provided pursuant to a prescription or order or when lawfully provided over-the-counter. You may request coverage for an alternative version of a contraceptive drug, device and other product if the Covered contraceptive drug, device and other product is not available or is deemed medically inadvisable, as determined by Your attending Health Care Provider.]

You may request a copy of Our Formulary. Our Formulary is also available on Our website at www.cdphp.com. You may inquire if a specific drug is Covered under this Rider by contacting Us at the number on Your ID card.

B. Refills.

We Cover Refills of Prescription Drugs only when dispensed at a retail, or mail order or designated pharmacy as ordered by an authorized Provider. Benefits for Refills will not be provided beyond one (1) year from the original prescription date. For prescription eye drop medication, We allow for the limited refilling of the prescription prior to the last day

of the approved dosage period without regard to any coverage restrictions on early Refill of renewals. To the extent practicable, the quantity of eye drops in the early Refill will be limited to the amount remaining on the dosage that was initially dispensed. Your Cost-Sharing for the limited Refill is the amount that applies to each prescription or Refill as set forth in the Schedule of Benefits section of this Rider.

C. Benefit and Payment Information.

- 1. Cost-Sharing Expenses.** You are responsible for paying the costs outlined in the Schedule of Benefits section of this Rider when Covered Prescription Drugs are obtained from a retail, or mail order or designated pharmacy.

[² You have a one (1) tier plan design, which means that You will have the same out-of-pocket expenses for all Prescription Drugs.]

[³ You have a three (3) tier plan design, which means that Your out-of-pocket expenses will generally be lowest for Prescription Drugs on tier 1 and highest for Prescription Drugs on tier 3. Your out-of-pocket expense for Prescription Drugs on tier 2 will generally be more than for tier 1 but less than tier 3.]

You are responsible for paying the full cost (the amount the pharmacy charges You) for any non-Covered Prescription Drug, and Our contracted rates (Our Prescription Drug Cost) will not be available to You.

- 2. Participating Pharmacies.** For Prescription Drugs purchased at a retail, or mail order or designated Participating Pharmacy, You are responsible for paying the lower of:
 - The applicable Cost-Sharing; or
 - The Prescription Drug Cost for that Prescription Drug.(Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

In the event that Our Participating Pharmacies are unable to provide the Covered Prescription Drug, and cannot order the Prescription Drug within a reasonable time, You may, with Our prior written approval, go to a Non-Participating Pharmacy that is able to provide the Prescription Drug. We will pay You the Prescription Drug Cost for such approved Prescription Drug less Your required in-network Cost-Sharing upon receipt of a complete Prescription Drug claim form. Contact Us at the number on Your ID card or visit Our website at www.cdphp.com to request approval.

- 3. Non-Participating Pharmacies.** We will not pay for any Prescription Drugs that You purchase at a Non-Participating retail or mail order Pharmacy other than as described above.
- 4. Designated Pharmacies.** If You require certain Prescription Drugs including, but not limited to specialty Prescription Drugs, We may direct You to a

Designated Pharmacy with whom We have an arrangement to provide those Prescription Drugs.

Generally, specialty Prescription Drugs are Prescription Drugs that are approved to treat limited patient populations or conditions; are normally injected, infused or require close monitoring by a Provider; or have limited availability, special dispensing and delivery requirements and/or require additional patient supports.

If You are directed to a Designated Pharmacy and You choose not to obtain Your Prescription Drug from a Designated Pharmacy, You will not have coverage for that Prescription Drug.

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Age related macular edema;
- Anemia, neutropenia, thrombocytopenia;
- [⁴ Contraceptives;]
- Cardiovascular;
- Crohn's disease;
- Cystic fibrosis;
- Cytomegalovirus;
- Endocrine disorders/neurologic disorders such as infantile spasms;
- Enzyme deficiencies/liposomal storage disorders;
- Gaucher's disease;
- Growth hormone;
- Hemophilia;
- Hepatitis B, hepatitis C;
- Hereditary angioedema;
- HIV/AIDS;
- Immune deficiency;
- Immune modulator;
- Infertility;
- Iron overload;
- Iron toxicity;
- Multiple sclerosis;
- Oncology;
- Osteoarthritis;
- Osteoporosis;
- Parkinson's disease;
- Pulmonary arterial hypertension;
- Respiratory condition;
- Rheumatologic and related conditions (rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, juvenile rheumatoid arthritis, psoriasis)
- Transplant;
- RSV prevention;

- Inherited Autoinflammatory Diseases;
- Phenylketonuria (PKU);
- Ulcerative Colitis;
- Allergy;
- Asthma;
- Alpha-1 Antitrypsin Deficiency.

- 5. Designated Retail Pharmacy for Maintenance Drugs.** You may also fill Your Prescription Order for Maintenance Drugs for up to a 90-day supply at a Designated retail Pharmacy after an initial 30-day supply [⁵, with the exception of contraceptive drugs, devices, or products which are available for a 12-month supply]. You are responsible for paying the lower of:
- The applicable Cost-Sharing; or
 - The Prescription Drug Cost for that Prescription Drug.
- (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills).

Following are the therapeutic classes of Prescription Drugs or conditions that are included in this program:

- Asthma;
- Blood pressure;
- Contraceptives;
- Diabetes;
- High cholesterol.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through a Designated retail Pharmacy by visiting Our website at www.cdphp.com or by calling the number on Your ID card. The Maintenance Drug list is updated periodically. Visit Our website at www.cdphp.com or call the number on Your ID card to find out if a particular Prescription Drug is on the maintenance list.

- 6. Mail Order.** Certain Prescription Drugs may be ordered through Our mail order pharmacy. You are responsible for paying the lower of:
- The applicable Cost-Sharing; or
 - The Prescription Drug Cost for that Prescription Drug.
- (Your Cost-Sharing will never exceed the Usual and Customary Charge of the Prescription Drug.)

To maximize Your benefit, ask Your Provider to write Your Prescription Order or Refill for a 90-day supply, with Refills when appropriate (not a 30-day supply with three (3) Refills). You may be charged the mail order Cost-Sharing for any

Prescription Orders or Refills sent to the mail order pharmacy regardless of the number of days supply written on the Prescription Order or Refill.

Prescription Drugs purchased through mail order will be delivered directly to Your home or office.

We will provide benefits that apply to drugs dispensed by a mail order pharmacy to drugs that are purchased from a retail pharmacy when that retail pharmacy has a participation agreement with Us and Our vendor in which it agrees to be bound by the same terms and conditions as a participating mail order pharmacy.

You or Your Provider may obtain a copy of the list of Prescription Drugs available through mail order by visiting Our website at www.cdphp.com or by calling the number on Your ID card.

- 7. Tier Status.** The tier status of a Prescription Drug may change periodically, but no more than four (4) times per calendar year, or when a Brand-Name Drug becomes available as a Generic Drug as described below, based on Our tiering decisions. These changes may occur without prior notice to You. However, if You have a prescription for a drug that is being moved to a higher tier or is being removed from Our Formulary, We will notify You at least 30 days before the change is effective. When such changes occur, Your Cost-Sharing may change. You may also request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of this Rider. You may access the most up to date tier status on Our website at www.cdphp.com or by calling the number on Your ID card.
- 8. When a Brand-Name Drug Becomes Available as a Generic Drug.** When a Brand-Name Drug becomes available as a Generic Drug, the tier placement of the Brand-Name Prescription Drug may change. If this happens, You will pay the Cost-Sharing applicable to the tier to which the Prescription Drug is assigned or the Brand-Name Drug will be removed from the Formulary and You no longer have benefits for that particular Brand-Name Drug. Please note, if You are taking a Brand-Name Drug that is being excluded or placed on a higher tier due to a Generic Drug becoming available, You will receive 30 days' advance written notice of the change before it is effective. You may request a Formulary exception for a Prescription Drug that is no longer on the Formulary as outlined below and in the External Appeal section of Your Certificate.
- 9. Formulary Exception Process.** If a Prescription Drug is not on Our Formulary, You, Your designee or Your prescribing Health Care Professional may request a Formulary exception for a clinically-appropriate Prescription Drug in writing, electronically or telephonically. The request should include a statement from Your prescribing Health Care Professional that all Formulary drugs will be or have been ineffective, would not be as effective as the non-Formulary drug, or would have adverse effects. If coverage is denied under Our standard or

expedited Formulary exception process, You are entitled to an external appeal as outlined in the External Appeal section of Your Certificate. Visit Our website at www.cdphp.com or call the number on Your ID card to find out more about this process.

Standard Review of a Formulary Exception. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 72 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You are taking the Prescription Drug, including any refills.

Expedited Review of a Formulary Exception. If You are suffering from a health condition that may seriously jeopardize Your health, life or ability to regain maximum function or if You are undergoing a current course of treatment using a non-Formulary Prescription Drug, You may request an expedited review of a Formulary exception. The request should include a statement from Your prescribing Health Care Professional that harm could reasonably come to You if the requested drug is not provided within the timeframes for Our standard Formulary exception process. We will make a decision and notify You or Your designee and the prescribing Health Care Professional by telephone no later than 24 hours after Our receipt of Your request. We will notify You in writing within three (3) business days of receipt of Your request. If We approve the request, We will Cover the Prescription Drug while You suffer from the health condition that may seriously jeopardize Your health, life or ability to regain maximum function or for the duration of Your current course of treatment using the non-Formulary Prescription Drug.

- 10. Supply Limits.** [⁶ Except for contraceptive drugs, devices, or products,] We will pay for no more than a 30-day supply of a Prescription Drug purchased at a retail pharmacy. You are responsible for one (1) Cost-Sharing amount for up to a 30-day supply.

[⁷ You may have the entire supply (of up to 12 months) of the contraceptive drug, device, or product dispensed at the same time. Contraceptive drugs, devices, or products are not subject to Cost-Sharing.]

Benefits will be provided for Prescription Drugs dispensed by a mail order pharmacy in a quantity of up to a 90-day supply. You are responsible for one (1) Cost-Sharing amount for a 30-day supply up to a maximum of two (2) Cost-Sharing amounts for a 90-day supply.

Specialty Prescription Drugs may be limited to a 30-day supply when obtained at a retail or mail order pharmacy. You may access Our website at www.cdphp.com or by calling the number on Your ID card for more information on supply limits for specialty Prescription Drugs.

Some Prescription Drugs may be subject to quantity limits based on criteria that We have developed, subject to Our periodic review and modification. The limit may restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply. You can determine whether a Prescription Drug has been assigned a maximum quantity level for dispensing by accessing Our website at www.cdphp.com or by calling the number on Your ID card. If We deny a request to Cover an amount that exceeds Our quantity level, You are entitled to an Appeal pursuant to the Utilization Review and External Appeal sections of Your Certificate.

- 11. Initial Limited Supply of Prescription Opioid Drugs.** If You receive an initial limited prescription for a seven (7) day supply or less of any schedule II, III, or IV opioid prescribed for Acute pain, and You have a Copayment, Your Copayment will be prorated. If You receive an additional supply of the Prescription Drug within the 30-day period in which You received the seven (7) day supply, Your Copayment for the remainder of the 30-day supply will also be prorated. In no event will the prorated Copayment(s) total more than Your Copayment for a 30-day supply.
- 12. Cost-Sharing for Orally-Administered Anti-Cancer Drugs.** Your Cost-Sharing for orally-administered anti-cancer drugs is at least as favorable to You as the Cost-Sharing amount, if any, that applies to intravenous or injected anticancer medications Covered under the Outpatient and Professional Services section of Your Certificate.
- 13. Split Fill Dispensing Program.** The split fill dispensing program is designed to prevent wasted Prescription Drugs if Your Prescription Drug or dose changes or if We contact You and You confirm that You have leftover Prescription Drugs from a previous fill. The Prescription Drugs that are included under this program have been identified as requiring more frequent follow up to monitor response to treatment and reactions. You will initially get up to a 15-day supply (or appropriate amount of medication needed for an average infertility treatment cycle) of Your Prescription Order for certain drugs filled at a Designated pharmacy instead of the full Prescription Order. You initially pay a lesser Cost-Sharing based on what is dispensed. The therapeutic classes of Prescription Drugs that are included in this program are: Antivirals/Anti-infectives, Infertility, Iron Toxicity, Mental/Neurologic Disorders, Multiple Sclerosis, Oncology and Drugs for Autoimmune Disorders. With the exception of Infertility drugs, this program applies for the first 60 days when You start a new Prescription Drug. For Infertility drugs, the program applies to Your infertility treatment cycle. This program will not apply upon You or Your Provider's request. You or Your Provider can opt out by visiting Our website at www.cdphp.com or by calling the number on Your ID card.

D. Medical Management.

This Rider includes certain features to determine when Prescription Drugs should be Covered, which are described below. As part of these features, Your prescribing Provider may be asked to give more details before We can decide if the Prescription Drug is Medically Necessary.

- 1. Preauthorization.** Preauthorization may be needed for certain Prescription Drugs to make sure proper use and guidelines for Prescription Drug coverage are followed. When appropriate, Your Provider will be responsible for obtaining Preauthorization for the Prescription Drug. Preauthorization is not required for Covered medications to treat substance use disorder, including opioid overdose reversal medications prescribed or dispensed to You.

For a list of Prescription Drugs that need Preauthorization, please visit Our website at www.cdphp.com or call the number on Your ID card. The list will be reviewed and updated from time to time. We also reserve the right to require Preauthorization for any new Prescription Drug on the market or for any currently available Prescription Drug which undergoes a change in prescribing protocols and/or indications regardless of the therapeutic classification, including if a Prescription Drug or related item on the list is not Covered under Your Rider. Your Provider may check with Us to find out which Prescription Drugs are Covered.

- 2. Step Therapy.** Step therapy is a process in which You may need to use one (1) or more types of Prescription Drugs before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for Your medical condition. When establishing a step therapy protocol, We will use recognized evidence-based and peer reviewed clinical review criteria that also takes into account the needs of atypical patient populations and diagnoses. We check certain Prescription Drugs to make sure that proper prescribing guidelines are followed. These guidelines help You get high quality and cost-effective Prescription Drugs. The Prescription Drugs that require Preauthorization under the step therapy program are also included on the Preauthorization drug list. If a step therapy protocol is applicable to Your request for coverage of a Prescription Drug, You, Your designee, or Your Health Care Professional can request a step therapy override determination as outlined in the Utilization Review section of Your Certificate.
- 3. Therapeutic Substitution.** Therapeutic substitution is an optional program that tells You and Your Providers about alternatives to certain prescribed drugs. We may contact You and Your Provider to make You aware of these choices. Only You and Your Provider can determine if the therapeutic substitute is right for You. We have a therapeutic drug substitutes list, which We review and update from time to time. For questions or issues about therapeutic drug substitutes, visit Our website at www.cdphp.com or call the number on Your ID card.

E. Limitations/Terms of Coverage.

1. We reserve the right to limit quantities, day supply, early Refill access and/or duration of therapy for certain medications based on Medical Necessity including acceptable medical standards and/or FDA recommended guidelines.
2. If We determine that You may be using a Prescription Drug in a harmful or abusive manner, or with harmful frequency, Your selection of Participating Pharmacies and prescribing Providers may be limited. If this happens, We may require You to select a single Participating Pharmacy and a single Provider that will provide and coordinate all future pharmacy services. Benefits will be paid only if You use the selected single Participating Pharmacy. Benefits will be paid only if Your Prescription Orders or Refills are written by the selected Provider or a Provider authorized by Your selected Provider. If You do not make a selection within 31 days of the date We notify You, We will select a single Participating Pharmacy and/or prescribing Provider for You.
3. Compounded Prescription Drugs will be Covered only when the primary ingredient is a Covered legend Prescription Drug, and are obtained from a pharmacy that is approved for compounding. All compounded Prescription Drugs require Your Provider to obtain Preauthorization. Compounded Prescription Drugs are on tier 3.
4. Various specific and/or generalized “use management” protocols will be used from time to time in order to ensure appropriate utilization of medications. Such protocols will be consistent with standard medical/drug treatment guidelines. The primary goal of the protocols is to provide Our Members with a quality-focused Prescription Drug benefit. In the event a use management protocol is implemented, and You are taking the drug(s) affected by the protocol, You will be notified in advance.
5. Injectable drugs (other than self-administered injectable drugs) and diabetic insulin, oral hypoglycemics, and diabetic supplies and equipment are not Covered under this section but are Covered under other sections of Your Certificate.
6. We do not Cover charges for the administration or injection of any Prescription Drug. Prescription Drugs given or administered in a Physician’s office are Covered under the Outpatient and Professional Services section of Your Certificate.
7. We do not Cover drugs that do not by law require a prescription, except for smoking cessation drugs, over-the-counter preventive drugs or devices provided in accordance with the comprehensive guidelines supported by HRSA or with an “A” or “B” rating from USPSTF, or as otherwise provided in Your Certificate. We do not Cover Prescription Drugs that have over-the-counter non-prescription equivalents, except if specifically designated as Covered in the drug Formulary.

Non-prescription equivalents are drugs available without a prescription that have the same name/chemical entity as their prescription counterparts. We do not Cover repackaged products such as therapeutic kits or convenience packs that contain a Covered Prescription Drug unless the Prescription Drug is only available as part of a therapeutic kit or convenience pack. Therapeutic kits or convenience packs contain one or more Prescription Drug(s) and may be packaged with over-the-counter items, such as gloves, finger cots, hygienic wipes or topical emollients.

8. We do not Cover Prescription Drugs to replace those that may have been lost or stolen.
9. We do not Cover Prescription Drugs dispensed to You while in a Hospital, nursing home, other institution, Facility, or if You are a home care patient, except in those cases where the basis of payment by or on behalf of You to the Hospital, nursing home, Home Health Agency or home care services agency, or other institution, does not include services for drugs.
10. We reserve the right to deny benefits as not Medically Necessary or experimental or investigational for any drug prescribed or dispensed in a manner contrary to standard medical practice. If coverage is denied, You are entitled to an Appeal as described in the Utilization Review and External Appeal sections of Your Certificate.
11. A pharmacy need not dispense a Prescription Order that, in the pharmacist's professional judgment, should not be filled.

F. General Conditions.

1. You must show Your ID card to a retail pharmacy at the time You obtain Your Prescription Drug or You must provide the pharmacy with identifying information that can be verified by Us during regular business hours. You must include Your identification number on the forms provided by the mail order pharmacy from which You make a purchase.
2. **Drug Utilization, Cost Management and Rebates.** We conduct various utilization management activities designed to ensure appropriate Prescription Drug usage, to avoid inappropriate usage, and to encourage the use of cost-effective drugs. Through these efforts, You benefit by obtaining appropriate Prescription Drugs in a cost-effective manner. The cost savings resulting from these activities are reflected in the Premiums for Your coverage.

We may also, from time to time, enter into agreements that result in Us receiving rebates or other funds ("rebates") directly or indirectly from Prescription Drug manufacturers, Prescription Drug distributors or others. Any rebates are based upon utilization of Prescription Drugs across all of Our business and not solely on any one Member's utilization of Prescription Drugs. Any rebates received by Us

may or may not be applied, in whole or part, to reduce premiums either through an adjustment to claims costs or as an adjustment to the administrative expenses component of Our Prescription Drug premiums. Any such rebates may be retained by Us, in whole or part, in order to fund such activities as new utilization management activities, community benefit activities and increasing reserves for the protection of Members. Rebates may change or reduce the amount of any Copayment or Coinsurance applicable under Our Prescription Drug coverage. If a Prescription Drug is eligible for a rebate, most of the rebate will be used to reduce the Allowed Amount for the Prescription Drug. Your Deductible or Coinsurance is calculated using that reduced Allowed Amount. The remaining value of that rebate will be used to reduce costs for all Members enrolled in coverage. Not all Prescription Drugs are eligible for a rebate, and rebates can be discontinued or applied at any time based on the terms of the rebate agreements. Because the exact value of the rebate will not be known at the time You purchase the Prescription Drug, the amount of the rebate applied to Your claim will be based on an estimate. Payment on Your claim and Your Cost-Sharing will not be adjusted if the later-determined rebate value is higher or lower than Our estimate.

G. Definitions.

Terms used in this section are defined as follows. (Other defined terms can be found in the Definitions section of Your Certificate).

- 1. Brand-Name Drug:** A Prescription Drug that: 1) is manufactured and marketed under a trademark or name by a specific drug manufacturer; or 2) We identify as a Brand-Name Prescription Drug, based on available data resources. All Prescription Drugs identified as “brand name” by the manufacturer, pharmacy, or Your Physician may not be classified as a Brand-Name Drug by Us.
- 2. Designated Pharmacy:** A pharmacy that has entered into an agreement with Us or with an organization contracting on Our behalf, to provide specific Prescription Drugs, including but not limited to, specialty Prescription Drugs. The fact that a pharmacy is a Participating Pharmacy does not mean that it is a Designated Pharmacy.
- 3. Formulary:** The list that identifies those Prescription Drugs for which coverage may be available under this Rider. This list is subject to Our periodic review and modification (no more than four (4) times per calendar year or when a Brand-Name Drug becomes available as a Generic Drug). To determine which tier a particular Prescription Drug has been assigned, visit Our website at www.cdphp.com or by calling the number on Your ID card.
- 4. Generic Drug:** A Prescription Drug that: 1) is chemically equivalent to a Brand-Name Drug; or 2) We identify as a Generic Prescription Drug based on available data resources. All Prescription Drugs identified as “generic” by the manufacturer, pharmacy or Your Physician may not be classified as a Generic Drug by Us.

- 5. Maintenance Drug:** A Prescription Drug used to treat a condition that is considered chronic or long-term and which usually requires daily use of Prescription Drugs.
- 6. Non-Participating Pharmacy:** A pharmacy that has not entered into an agreement with Us to provide Prescription Drugs to Members. We will not make any payment for prescriptions or Refills filled at a Non-Participating Pharmacy other than as described above.
- 7. Participating Pharmacy:** A pharmacy that has:
- Entered into an agreement with Us or Our designee to provide Prescription Drugs to Members;
 - Agreed to accept specified reimbursement rates for dispensing Prescription Drugs; and
 - Been designated by Us as a Participating Pharmacy.
- A Participating Pharmacy can be either a retail or mail-order pharmacy.
- 8. Prescription Drug:** A medication, product or device that has been approved by the FDA and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill and is on Our Formulary. A Prescription Drug includes a medication that, due to its characteristics, is appropriate for self administration or administration by a non-skilled caregiver.
- 9. Prescription Drug Cost:** The amount, including a dispensing fee and any sales tax, as contracted between Us and Our pharmacy benefit manager for a Covered Prescription Drug dispensed at a Participating Pharmacy. If Your Certificate includes coverage at Non-Participating Pharmacies, the Prescription Drug Cost for a Prescription Drug dispensed at a Non-Participating Pharmacy is calculated using the Prescription Drug Cost that applies for that particular Prescription Drug at most Participating Pharmacies.
- 10. Prescription Order or Refill:** The directive to dispense a Prescription Drug issued by a duly licensed Health Care Professional who is acting within the scope of his or her practice.
- 11. Usual and Customary Charge:** The usual fee that a pharmacy charges individuals for a Prescription Drug without reference to reimbursement to the pharmacy by third parties as required by New York Education Law Section 6826-a.

Prescription Drug Coverage Schedule of Benefits

PRESCRIPTION	Preferred	Participating	Non-Participating	Limits
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<p>DRUGS</p> <p>*Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF and obtained at a participating pharmacy.</p>	<p>Provider Member Responsibility for Cost-Sharing</p>	<p>Provider Member Responsibility for Cost-Sharing</p>	<p>Provider Member Responsibility for Cost-Sharing</p>	
<p>[⁸ Deductible</p>		<p>[⁹ Deductible then] [¹⁰ [¹¹ \$100; \$250; \$500; \$750] Deductible then] [¹² Not Subject to the Medical Deductible] Deductible is per Member</p>		<p>]</p>
<p>Retail Pharmacy</p>				
<p>30-day supply</p> <p>[Tier 1</p> <p>Tier 2</p>	<p>N/A</p> <p>N/A</p>	<p>[¹³ Covered in Full] [¹⁴ \$4; \$5; \$10 Copayment] [¹⁵ 10%; 50% Coinsurance]]</p> <p>[¹⁶ Covered in Full] [¹⁷ \$20; \$25; \$30; \$40; \$45; \$50 Copayment] [¹⁸ 25%; 50% Coinsurance]</p>	<p>Non-Participating</p>	<p>See benefit for description</p>

<p>Tier 3}</p> <p>Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.</p>	<p>N/A</p>	<p>[¹⁹ Not Covered]</p> <p>[²⁰ Covered in Full]</p> <p>[²¹ \$35; \$40; \$50; \$60; \$70; \$75; \$80; \$100 Copayment]</p> <p>[²² 40%; 50% Coinsurance]</p> <p>[²³ Not Covered]</p> <p>]</p> <p>[²⁴ Coinsurance not to exceed [²⁵ \$100] per 30-day supply]</p> <p>[²⁶ Tier-1 and Mail Order Carved Out of the Deductible]</p> <p>[²⁷ Up to a per Plan Year maximum of [²⁸ \$3,000], then coverage for tier-1, tier-2 and tier-3 Prescription Drugs is [²⁹ 50%] Coinsurance. The Plan Year maximum is based on the amount CDPHP pays of the allowable charge for the prescription drug less the tier-1, tier-2, or tier-3 Copayment]</p>	<p>Provider services are not Covered and You pay the full cost</p>	
<p>Mail Order Pharmacy</p>	<p>Up to a 90-day supply</p>			
<p>Up to a 90-day supply</p>		<p>[Deductible then] [[\$100; \$250; \$500; \$750] Deductible then]</p> <p>[Not Subject to the</p>		

<p>Tier 1</p>	<p>N/A</p>	<p>Medical Deductible] Deductible is per Member</p> <p>[³⁰ Covered in Full] [³¹ \$10; \$13; \$20; \$25 Copayment] [³² 10%; 50% Coinsurance]]</p>		
<p>Tier 2</p>	<p>N/A</p>	<p>[³³ Covered in Full] [³⁴ \$40; \$50; \$60; \$63; \$75; \$100; \$113; \$125 Copayment] [³⁵ 25%; 50% Coinsurance] [³⁶ Not Covered]</p>	<p>Non-Participating Provider services are not Covered and You pay the full cost</p>	<p>See benefit for description</p>
<p>Tier 3</p>	<p>N/A</p>	<p>[³⁷ Covered in Full] [³⁸ \$80; \$88; \$100; \$125; \$150; \$160; \$175; \$188; \$200; \$250 Copayment] [³⁹ 40%; 50% Coinsurance] [⁴⁰ Not Covered]]</p> <p>[⁴¹ Coinsurance not to exceed [⁴² \$300] per 90-day supply]</p> <p>[⁴³ Tier-1 and Mail Order Carved Out of the Deductible]</p> <p>[⁴⁴ Up to a per Plan Year maximum of [⁴⁵ \$3,000], then coverage for tier-1, tier-2 and tier-3 Prescription Drugs is [⁴⁶ 50%] Coinsurance. The Plan Year maximum is based on the</p>		

		amount CDPHP pays of the allowable charge for the prescription drug less the tier-1, tier-2, or tier-3 Copayment]		
Enteral Formulas	N/A	Follows Cost-Share for Retail Pharmacy or Mail Order Pharmacy above	Non-Participating Provider services are not Covered and You pay the full cost	See benefit for description

Controlling Certificate.

All of the terms, conditions, limitations, and exclusions of Your Certificate to which this Rider is attached shall also apply to this Rider except where specifically changed by this Rider.

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC.



By:

**John D. Bennett, MD, FACC
President and CEO**

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of CDPHP® Group Medicare (HMO)

This booklet gives you the details about your Medicare health care January 1 – December 31, 2021. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, CDPHP Group Medicare (HMO) is offered by Capital District Physicians' Health Plan, Inc. (When this Evidence of Coverage says "we," "us," or "our," it means Capital District Physicians' Health Plan, Inc. When it says "plan" or "our plan," it means CDPHP Group Medicare (HMO)).

Please contact our Member Services number at (518) 641-3950 or 1-888-248-6522 for additional information. (TTY users should call 711). Hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are Monday – Friday, 8 a.m. – 8 p.m. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Member Services has free language-interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

This information is available in different formats, including large print. Please call Member Services if you need plan information in another format.

Benefits, premium, and/or copayments/coinsurance may change on January 1, 2022.

The provider network may change at any time. You will receive notice when necessary.

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2021 Evidence of Coverage**Table of Contents**

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CHAPTER 1

Getting started as a member

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Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in CDPHP Group Medicare (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, CDPHP Group Medicare (HMO).

There are different types of Medicare health plans. CDPHP Group Medicare (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. CDPHP Group Medicare (HMO) does not include Part D prescription drug coverage.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

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

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of CDPHP Group Medicare (HMO).

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

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

This *Evidence of Coverage* is part of our contract with you about how CDPHP Group Medicare (HMO) *covers* your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called “riders” or “amendments.”

The contract is in effect for months in which you are enrolled in CDPHP Group Medicare (HMO) between January 1, 2021 and December 31, 2021.

Chapter 1. Getting started as a member

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of CDPHP Group Medicare (HMO) after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Chapter 1. Getting started as a member**Section 2.3 Here is the plan service area for CDPHP Group Medicare (HMO)**

Although Medicare is a Federal program, CDPHP Group Medicare (HMO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York state: Albany, Broome, Chenango, Columbia, Delaware, Dutchess, Essex, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida, Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

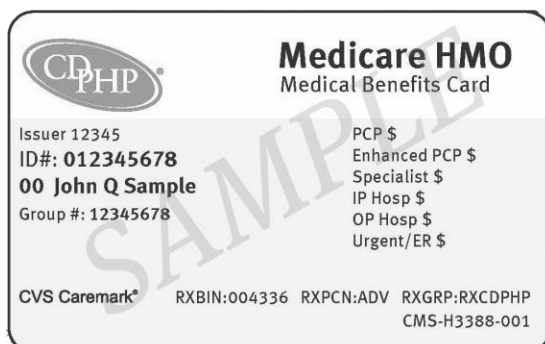
It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?**Section 3.1 Your plan membership card – Use it to get all covered care**

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



Enrollees: For Member Services call 518-641-3950 or 1-888-248-6522 (TTY/TDD 711)
Providers: Call 518-641-3500 or 1-800-926-7526 for verification of eligibility.
Hospitals: Call 518-641-4100 or 1-800-274-2332 for approval within 24 hours of an emergency admission.
Mental Health/Chemical Dependency services: Call 1-888-320-9584
Fraud/Compliance Hotline: 1-800-280-6885 Unauthorized or fraudulent use of this card to obtain services is punishable by law.
Capital District Physicians' Health Plan, Inc.
 500 Patroon Creek Blvd. • Albany, NY 12206-1057 www.cdphp.com

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Use this medical card at a physician's office for medical services and at a pharmacy for Part B-covered drugs.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your CDPHP Group Medicare (HMO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider Directory</i>: Your guide to all providers in the plan's network
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The *Provider Directory* lists our network providers.

What are “network providers”?

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 any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at <https://www.cdphp.com>.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which CDPHP Group Medicare (HMO) *authorizes* use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. For the most up-to-date provider information, please visit <https://findadoc.cdphp.com> or download the My CDPHP app to your smartphone. Call the Member Services department if you want more

Chapter 1. Getting started as a member

information on a doctor's qualifications, such as where he or she completed medical school or residency, or if he or she is board-certified.

SECTION 4 Your monthly premium for CDPHP Group Medicare (HMO)

Section 4.1 How much is your plan premium?

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

What happens if your employer group or union doesn't pay its plan premiums, or doesn't pay them on time?

If your employer group's or union's coverage through CDPHP is terminated due to nonpayment of premiums or any other reason, CDPHP will provide you with written notice of the termination. You then will have Original Medicare coverage. You may be eligible to enroll in any individual Medicare plan offered by CDPHP or another plan provider. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2021* gives information about the Medicare premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

Depending on the open enrollment period for your employer group, your premium may change during the year. Contact your employer group for questions on your group's enrollment period. We are allowed to *decrease* plan premiums at any time during the calendar year. If we decide to decrease plan premiums during the calendar year, we will let your employer group know in

Chapter 1. Getting started as a member

writing. **Increases in your plan premium are only allowed at the beginning of each contract year, and must be approved by Medicare.** We will notify your employer group in advance if there will be any changes for the next contract year in plan premiums or in the amounts you will have to pay when you get covered services. If there are any changes for the next contract year, they will take effect on your employer group's anniversary date.

SECTION 5 Please keep your plan membership record up to date

Section 5.1	How to help make sure that we have accurate information about you
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Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage Primary Care Physician.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet). Or, log into <https://www.cdphp.com>.

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

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Chapter 1. Getting started as a member

Once each year, we will send you a letter that lists any other medical insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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

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

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

Chapter 1. Getting started as a member

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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Chapter 2. Important phone numbers and resources

SECTION 1 CDPHP Group Medicare (HMO) contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to CDPHP Group Medicare (HMO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057
WEBSITE	https://www.cdphp.com

How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.

A “coverage decision” is a decision we make about your benefits and coverage or about the amount we will pay for your medical services included in your plan. For more information on asking for coverage decisions about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Chapter 2. Important phone numbers and resources

Method	Coverage Decisions, Appeals, or Complaints For Medical Care – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057 info@cdphp.com
WEBSITE	https://www.cdphp.com
MEDICARE WEBSITE	You can submit a complaint about CDPHP Group Medicare (HMO) directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services*).

Chapter 2. Important phone numbers and resources

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	Payment Requests – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057
WEBSITE	https://www.cdphp.com

SECTION 2 Medicare

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Chapter 2. Important phone numbers and resources

Method	Medicare – Contact Information
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>https://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about CDPHP Group Medicare (HMO):</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about CDPHP Group Medicare (HMO) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

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

Chapter 2. Important phone numbers and resources

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

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

Method	Health Insurance Information Counseling & Assistance Program (New York State SHIP) – Contact Information
CALL or WRITE	<p>Albany County: Department for Aging, 162 Washington Ave., Albany, NY 12210, (518) 447-7198</p> <p>Broome County: Broome County Office Building, 60 Hawley St., 4th Floor, P.O. Box 1766, Binghamton, NY 13902-1766, (607) 778-2411</p> <p>Chenango County: County Office Building., 5 Court St., Norwich, NY 13815-1794, (607) 337 1770</p> <p>Clinton County: 135 Margaret St., Suite 105, Plattsburgh, NY 12901, (518) 565-4560</p> <p>Columbia County: Office for the Aging, 325 Columbia St., Suite 231, Hudson, NY 12534, (518) 828-4258</p> <p>Delaware County: Office for the Aging, 97 Main St., Suite 2, Delhi, NY 13753, (607) 746-6333</p> <p>Dutchess County: Dutchess County Office for the Aging, 27 High Street, Poughkeepsie, NY 12601-1962, (845) 486-2555</p> <p>Essex County: Office for the Aging, P.O. Box 217, 132 Water St., Elizabethtown, NY 12932-0217, (518) 873-3695</p> <p>Franklin County: 355 W. Main St., 3rd Floor, Malone, NY 12953, (518) 481-1635</p> <p>Fulton County: Office for Aging, 19 N. William St., Johnstown, NY 12095-2534, (518) 736-5650</p> <p>Greene County: Department of the Aging and Human Connects, 159 Jefferson Heights., Catskill, NY 12414, (518) 719-3555</p> <p>Hamilton County: Warren/Hamilton Counties Office for the Aging, Human Services Building, 1340 State Route 9, Lake George, NY 12845, (518) 761-6347</p> <p>Herkimer County: Office for the Aging, 109 Mary St., Suite 1101, Herkimer, NY 13350-2924, (315) 867-1195</p> <p>Madison County: Office for the Aging, 138 Dominick Bruno Blvd., Canastota, NY 13032, (315) 697-5700</p> <p>Montgomery County: Office for the Aging, 135 Guy Park Ave., Amsterdam, NY 12010, (518) 843-2300 Ext. 229</p> <p>Oneida County: Office for Aging and Continuing Care, 300 W. Dominick St., Rome, NY 13440, and 800 Park Ave., Utica, NY 13501, (315) 798-5456</p> <p>Orange County: Orange County Office for the Aging, 40 Matthews Street, 3rd Floor - Suite 305, Goshen, NY 10924, (845) 615-3700</p> <p>Otsego County: Meadows Office Complex, Suite 5, 140 County Highway 33W, Cooperstown, NY 13326, (607) 547-4232</p> <p>Rensselaer County: Unified Family Services, Department for the Aging, 1600 Seventh Ave., 4th floor, Troy, NY 12180-3798, (518) 270-2730</p>

Chapter 2. Important phone numbers and resources

Saratoga County: Office for the Aging, 152 W. High St., Ballston Spa, NY 12021-3528, (518) 884-4100

Schenectady County: Department of Senior and Long Term Care Services, Schaffer Heights, 107 Nott Terrace, Suite 305, Schenectady, NY 12308, (518) 382-8481

Schoharie County: Office for the Aging, 113 Park Place, Suite 3, Schoharie, NY 12157, (518) 295-2001

Tioga County: Tioga Opportunities, Inc. – Aging Services, 9 Sheldon Guile Blvd., Owego, NY 13827, (607) 687-4120

Ulster County: Ulster County Office for the Aging, 1003 Development Court, Kingston, NY 12401, (845) 340-3456

Warren County: Warren/Hamilton Counties Office for the Aging, Human Services Building, 1340 State Route 9, Lake George, NY 12845, (518) 761-6347

Washington County: Washington County CARES, Office for Aging and Disability Resources, 383 Broadway, Fort Edward, NY 12828, (518) 746-2420

WEBSITE You can learn more about HIICAP by visiting their website (<https://www.aging.ny.gov>).

SECTION 4 Quality Improvement Organization

(paid by Medicare to check on the quality of care for people with Medicare)

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta (New York's Quality Improvement Organization)
CALL	1-866-815-5440
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Chapter 2. Important phone numbers and resources

Method	Livanta (New York's Quality Improvement Organization)
WRITE	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	https://www.BFCCQIOAREA1.com

SECTION 5 Social Security

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid
 (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.

Chapter 2. Important phone numbers and resources

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

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

To find out more about Medicaid and its programs, contact the New York State Medicaid Office.

Method	New York State Medicaid – Contact Information
CALL	1-800-541-2831
WRITE	New York State Department of Health Corning Tower Empire State Plaza Albany, NY 12237
WEBSITE	https://www.health.ny.gov/health_care/medicaid

SECTION 7 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Chapter 2. Important phone numbers and resources

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday.</p> <p>If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
WEBSITE	https://secure.rrb.gov/

SECTION 8 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services**Chapter 3. Using the plan's coverage for your medical services**

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Chapter 3. Using the plan's coverage for your medical services

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

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

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

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

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

As a Medicare health plan, CDPHP Group Medicare (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

CDPHP Group Medicare (HMO) will generally cover your medical care as long as:

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

Chapter 3. Using the plan's coverage for your medical services

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
 - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care
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What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. A PCP can also assist with coordinating the rest of the covered services you need, including obtaining prior authorization (PA), when applicable.

Chapter 3. Using the plan's coverage for your medical services

What is Enhanced Primary Care?

Enhanced Primary Care is a partnership between CDPHP and many network physicians who are committed to quality and spend more time with patients, offer expanded office hours, and deliver better, more comprehensive care.

To find an Enhanced Primary Care physician near you, use the Find-A-Doc search tool at <https://findadoc.cdphp.com>. Select “Enhanced Primary Care” in the “Select a Specialty” drop-down menu to view all Enhanced Primary Care physicians.

How do you choose your PCP?

When selecting a PCP, you should select a doctor who specializes in internal medicine, family practice, or general practice as listed in the Directory of Plan Practitioners and Providers. Women may also receive care from an obstetrician/gynecologist without an authorization from their PCP.

Changing your PCP

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

Changing your PCP is as easy as calling Member Services or logging into <https://www.cdphp.com>. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. Member Services will help make sure that you can continue with the specialty care and other services you have been getting. They will confirm that the PCP you select is accepting new patients. Member Services will change your membership record to show the name of your new PCP. The change will be effective immediately upon receipt of the request.

Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area).

Chapter 3. Using the plan's coverage for your medical services

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 2.3	How to get care from specialists and other network providers
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A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

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

Your PCP will provide most of your routine or basic health care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes 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 network providers about your care and how it is going.

You are not required to obtain or submit a referral slip. Your PCP can send you to another network provider without filing any special paperwork or getting a referral number. Instead, when visiting a network specialist for referred care, be sure to give them your PCP's information.

Your PCP or treating provider is responsible for contacting CDPHP to request prior authorization (PA) for services denoted as requiring PA in the Medical Benefits Chart (Chapter 4, Section 2.1). In the event that the PA request is submitted by someone other than your treating provider, CDPHP may contact the treating provider for informational purposes prior to rendering a decision regarding the requested services.

Please note that certain services, including inpatient hospitalization, still need prior authorization by our plan. For a complete list of benefits requiring prior authorization, please see the Medical Benefits Chart in Chapter 4 of this booklet.

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

It is important to know that we may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

Chapter 3. Using the plan's coverage for your medical services

- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

Please contact us by calling Member Services at (518) 641-3950 or 1-888-248-6522.

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

If you are outside the plan's service area and have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation, our plan covers urgently needed care that you get from any provider. Emergency care is always covered. See Section 3 below for more information about emergency and urgently needed care.

In addition, plans must cover dialysis services for ESRD enrollees who have traveled outside the plan's service area and are not able to access contracted ESRD providers.

All other routine medical care that you receive from a provider who is not part of our network requires prior authorization from our plan. If you need to receive routine medical care from an out-of-network provider, contact Member Services to obtain prior authorization.

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

Section 3.1 Getting care if you have a medical emergency**What is a "medical emergency" and what should you do if you have one?**

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.

If you have a medical emergency:

Chapter 3. Using the plan's coverage for your medical services

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services at (518) 641-3950 or 1-888-248-6522 Monday through Friday from 8 a.m. to 8 p.m. TTY users should call 711.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

In addition, you are covered worldwide for medically necessary emergency care. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet. If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

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

What if it wasn't a medical emergency?

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

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

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

Chapter 3. Using the plan's coverage for your medical services**Section 3.2 Getting care when you have an urgent need for services****What are “urgently needed services”?**

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

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.

In most situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable (e.g., if you need care after normal business hours) or contracted providers are inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

You can contact your primary care physician for instructions and advice for urgently needed care. In addition, CDPHP has the following resources available to assist you:

- We cover online internet consultations with providers who participate in the CDPHP telemedicine program for medical conditions that are not an emergency condition. Our telemedicine program allows members to communicate with providers through two-way video, and can be easily accessed through our Member site at <https://www.cdphp.com>.
- Use our web tool, <https://findadoc.cdphp.com>, to locate urgent care centers near you.
- Find an urgent care center via the My CDPHP app. Visit <https://www.cdphp.com/mobile> to download the app to your smartphone.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Our plan covers worldwide emergency and urgent services outside the United States.

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Our plan does not cover any other non-emergency services if you receive the care outside of the United States.

Section 3.3 Getting care during a disaster

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

Please visit the following website: <https://www.cdphp.com> for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

CDPHP Group Medicare (HMO) covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

Chapter 3. Using the plan's coverage for your medical services

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Expenses incurred after a benefit has been exhausted do not apply toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare *first* needs to approve the research study. If you participate in a study that Medicare *has not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Chapter 3. Using the plan's coverage for your medical services**Section 5.2 When you participate in a clinical research study, who pays for what?**

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (<https://www.medicare.gov>).

Chapter 3. Using the plan's coverage for your medical services

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Chapter 3. Using the plan's coverage for your medical services

If you get care from a religious non-medical health care institution, all inpatient hospital coverage limits apply. For more information, please refer to "Inpatient Hospital Care" in the benefits chart in Chapter 4 on pages 54-56.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of CDPHP Group Medicare (HMO), however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of CDPHP Group Medicare (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of CDPHP Group Medicare (HMO) the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021 is \$2,500. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your maximum out-of-pocket amount). If you reach the maximum out-of-pocket amount of \$2,500, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you

As a member of CDPHP Group Medicare (HMO) an important protection for you is you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services CDPHP Group Medicare (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.” Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021 Handbook*. View it online at <https://www.medicare.gov> or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.



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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Ambulance services***

- Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.
- Non-emergency transportation by ambulance is appropriate if it is 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.

\$75 copayment for each one-way trip for Medicare-covered ambulance benefits. Prior authorization is required for air ambulance services.

Medically necessary interfacility transfers (not at patient's request) are not subject to copayment.





 **Annual wellness visit**

If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.



Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.

There is no coinsurance, copayment, or deductible for the annual wellness visit.



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</p>	<p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months 	<p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • We cover only manual manipulation of the spine to correct subluxation 	<p>\$20 copayment to correct subluxation for each Medicare-covered visit.</p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover:</p> <p>Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.</p>	<p>\$20 copayment for Medicare-covered non-routine dental benefits.</p> <p>You are reimbursed up to \$150 for routine, preventive dental visits every year. Submit your receipt and proof of payment to CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206. This benefit may be used at any dental provider, in or out of network.</p> <p>NOTE: Periodontal cleanings are not considered routine and are excluded from coverage.</p>
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions 	<p>No copayment for blood glucose monitors (limited to one per year) and blood glucose test strips (limited to a 90-day supply) made by Ascensia Diabetes Care and purchased at a network pharmacy; if you use a monitor or test strips made by a different manufacturer, contact Member Services for more information or to request an exception.</p> <p>\$10 or 20% of the Medicare-allowed fee (whichever is less) for up to a 90-day supply of each diabetic supply covered under Part B (including lancets, glucose control solutions, insulin pump supplies, reservoirs).</p> <p>20% of the Medicare-allowed fee, for each diabetic monitoring or DME item covered under Part B (including insulin pumps, therapeutic custom molded shoes and inserts one pair per calendar year, etc.).</p> <p>No copayment for Medicare-covered diabetes self-management training.</p> <p>Diabetic pharmaceuticals (including oral agents, insulin preparations, etc.) are covered under Part D prescription drug coverage and therefore are not covered by your CDPHP Group Medicare (HMO) plan.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment (DME) and related supplies* (For a definition of “durable medical equipment,” see Chapter 10 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special-order it for you.</p> <p>*Prior authorization is required for:</p> <ul style="list-style-type: none"> • Rentals of each covered item. • Purchases of each covered item totaling a \$1,000 or more. • Repairs totaling \$1,000 or more. • Adjustments and/or replacement of DME in accordance with Medicare standards. 	<p>20% of the Medicare-allowed fee, for each Medicare-covered item.</p> <p>Coinsurance is based on the Medicare-allowed fee, which may be less than the billed charge.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Our plan covers emergency care anywhere in the world.</p>	<p>\$75 copayment for Medicare-covered emergency room visits. Copayment is waived if you are admitted to the hospital within 24 hours for the same condition.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan, and your cost is the cost-sharing you would pay at a network hospital.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs</p> <p>We cover a variety of services designed to help keep you healthy.</p> <p>Call Member Services at (518) 641-3950 or 1-888-248-6522 for more details.</p> <p>Programs include, but are not limited to:</p> <ul style="list-style-type: none">•	<p>There is no coinsurance, copayment, or deductible for health and wellness education programs.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p>	<p>\$20 copayment for one annual routine hearing exam.</p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Home health agency care**

Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

No copayment.

Covered services include, but are not limited to:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical and social services
- Medical equipment and supplies

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Drugs for symptom control and pain relief• Short-term respite care• Home care	<p>When you 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 CDPHP Group Medicare (HMO).</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Services that are covered for you****What you must pay when you get these services****Hospice care (continued)**

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.



For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:

- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services
- If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare)

For services that are covered by CDPHP Group Medicare (HMO) but are not covered by Medicare Part A or B: CDPHP Group Medicare (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• Other vaccines if you are at risk and they meet Medicare Part B coverage rules	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>
<ul style="list-style-type: none">• 	

Chapter 4. Medical Benefits Chart (what is covered and 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.

Covered services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services

There is no copayment for inpatient hospital stays.

A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If CDPHP Group Medicare (HMO) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services 	<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay.</p> <ul style="list-style-type: none"> • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. Contact the plan for details about coverage in a psychiatric hospital beyond 190 days. • The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. 	<p>There is no copayment for inpatient mental health care.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay**

If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:

- Physician services
- Diagnostic tests (like lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

\$20 copayment applies for physician services.

\$20 copayment for each Medicare-covered laboratory service. Copayment waived if service provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.

\$20 copayment for each Medicare-covered radiation therapy service.

\$20 copayment per date of service for X-rays.



\$40 copayment per date of service for each Medicare-covered advanced imaging study such as CT, CTA, MRI, MRA, or PET scans.

No copayment for surgical dressings.


20% of the Medicare-allowed fee, for each Medicare-covered splint, cast, or device to reduce fractures or dislocations, orthotic and/or prosthetic.

\$20 copayment for Medicare-covered physical, occupational, and speech therapy sessions.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Aranesp® and Retacrit) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	<p>\$20 copayment per date of service for Medicare-covered Part B drugs administered in an outpatient or office setting.</p> <p>\$20 per prescription for Part B drugs administered by a retail pharmacy.</p> <p>Prolia is subject to step therapy.</p> <p>Please note, an office visit or outpatient facility copayment will apply if additional services are rendered by your treating provider, depending on place of service billed by the provider.</p> <p>Medicare Part B covered prescriptions administered during an inpatient stay do not apply cost-sharing.</p> <p>No copayment for allergy injections.</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Opioid treatment program services</p> <p>Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:</p> <ul style="list-style-type: none"> • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing <p>Medically necessary and reasonable services to treat addiction and abuse disorders, diagnosis, detoxification (removal of toxic substance), and outpatient rehabilitation services will be provided in case of substance abuse or addiction. To learn more, please call the CDPHP Behavioral Health Access Center during business hours at 1-888-320-9584 .</p>	<p>\$20 copayment for each Medicare-covered substance use counseling visit.</p> <p>\$20 copayment for each Medicare-covered individual and group therapy per date of service.</p> <p>\$20 copayment per Medicare-covered Part B drug. Multiple copayments may apply if additional services are rendered.</p> <p>\$20 copayment for each Medicare-covered laboratory service. Copayment waived if service provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Outpatient diagnostic tests and therapeutic services and supplies**

Covered services include, but are not limited to:

- X-rays
- Radiation (radium and isotope) therapy including technician materials and supplies
- Advanced imaging studies (such as CT, CTA, MRI, MRA, and PET scans).
- Cardiovascular monitoring services, including echocardiograms and cardiac stress tests.
- Surgical supplies, such as dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Laboratory tests
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used
- Other outpatient diagnostic tests

Note: Member cost-share is based upon the services rendered and the clinical setting in which they are performed. If services are billed by a hospital, see Outpatient Hospital Services for cost-share, as they may be higher.

\$20 copayment for each Medicare-covered X-ray or ultrasound.

\$20 copayment for each Medicare-covered radiation therapy service.

\$40 copayment per date of service for each Medicare-covered advanced imaging study.

\$20 copayment for cardiovascular monitoring services. This copay is in addition to applicable physician cost-sharing.

No copayment for surgical supplies/dressings.

20% coinsurance of the Medicare-allowed fee, for each Medicare-covered splint, cast or device to reduce fractures and dislocations.

\$20 copayment for each Medicare-covered laboratory service. (Copayment waived if service provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies (continued)</p>	<p>No copayment for blood storage. Transfusion services rendered in outpatient department are subject to outpatient facility copayment.</p>
<p>Outpatient hospital observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at _ or by calling 1-800- MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$75 copayment.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Outpatient hospital services**

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can't give yourself

\$75 copayment for emergency room services.

\$20 copayment applies for outpatient clinic services. Multiple copayments may apply if additional services are rendered.

\$75 copayment for outpatient surgery billed by a hospital.

\$75 copayment for surgery at a freestanding ambulatory surgery center.

\$20 copayment for each Medicare-covered laboratory service. (Copayment waived if service provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.)

\$20 copayment for cardiovascular monitoring services.

There is no cost-share for Medicare-covered partial hospitalization services.

\$20 copayment for Medicare-covered X-rays and ultrasounds per date of service.

\$20 copayment for each Medicare-covered radiation therapy service per date of service.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services (continued)</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$40 copayment per date of service for each Medicare-covered advanced imaging study.</p> <p>Coinsurance is 20% of the Medicare-allowed fee, for each Medicare-covered item or device.</p> <p>No copayment for Medicare-covered preventive services as denoted in this Evidence of Coverage when provided in accordance with Medicare guidelines. Note: additional testing or services ordered, rendered, or recommended during preventive visits will apply to the plan-defined cost-sharing, as they are outside the scope of preventive services.</p> <p>\$20 copayment per Medicare-covered Part B drug. Multiple copayments may apply if additional services are rendered.</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$20 copayment for each Medicare-covered date of service.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$20 copayment for Medicare-covered physical, occupational, and speech therapy sessions.</p>
<p>Outpatient substance abuse services</p> <p>Medically necessary and reasonable services to treat addiction and abuse disorders, diagnosis, detoxification (removal of toxic substance), and outpatient rehabilitation services will be provided in case of substance abuse or addiction. To learn more, please call the CDPHP Behavioral Health Access Center during business hours at 1-888-320-9584</p>	<p>\$20 copayment for each Medicare-covered visit.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>\$75 copayment per date of service billed by an outpatient hospital or hospital-owned facility.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>There is no cost-share for Medicare-covered partial hospitalization services.</p> <p>Contact the Behavioral Health Access Center at 1-888-320-9584 or (518) 641-3600 for more information.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment • 	<p>Physician copayments do not apply for outpatient hospital facility or ambulatory surgical center visits. You will be responsible for the applicable facility cost-sharing for those services.</p> <p>\$20 copayment per Doctor On Demand telemedicine visit.</p> <p>\$20 copayment per Primary Care Physician visit.</p> <p>\$20 specialist copayment per visit.</p> <p>\$20 copayment for one annual routine hearing exam.</p> <p>Copayments do apply for telehealth and telemedicine services, including anticoagulation management. Services billed by a primary care physician will apply a PCP copayment, and services billed by a specialist or anticoagulation management vendor will apply the specialist copayment.</p> <p>\$20 copayment for second surgical opinion.</p> <p>\$20 copayment for Medical-covered non-routine dental care visit.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits (continued)</p> <ul style="list-style-type: none"> • Remote evaluation of pre-recorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours—if you are an established patient <u>and</u> the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) • One routine annual physical only when billed by a physician specializing in internal medicine, general medicine, or family practice. 	<p>No copayment for routine annual physical. No copayment for EKG when performed during a routine annual physical.</p> <p>No copayment for allergy injections.</p> <p>Please note, an office visit or outpatient facility copayment will apply if additional services are rendered by your treating provider, depending on place of service billed by the provider.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>\$20 copayment per visit.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<p>Prosthetic devices and related supplies*</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>*Prior authorization required for:</p> <ul style="list-style-type: none"> • Rentals of each covered item. • Purchases of each covered item totaling a \$1,000 or more. • Repairs totaling \$1,000 or more. • Adjustments and/or replacement of DME in accordance with Medicare standards. 	<p>20% coinsurance percentage of the Medicare-allowed fee, for each Medicare-covered item per date of service.</p> <p>All colostomy supplies are covered in full.</p>
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p> <p>The plan covers up to 36 additional pulmonary rehabilitation visits.</p>	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written 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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."</p>	<p>No copayment for kidney disease education services.</p> <p>\$20 copayment for in- and out-of-area renal dialysis. Out-of-area renal dialysis services are covered only in the United States.</p> <p>See the "Inpatient Hospital Care" benefit for specific inpatient dialysis cost sharing information.</p> <p>No copayment for self-dialysis training.</p> <p>20% coinsurance of the allowed fee for each Medicare-covered item for home dialysis.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care*</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 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. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services 	<p>There is no cost-share for skilled nursing facility services.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the plan-defined cost-share for each benefit period. There is no limit to the number of benefit periods you can have.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care (continued)</p> <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital 	
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>In addition, eligible CDPHP members have access to up to eight telephonic tobacco-cessation sessions with a quit coach per year. Members can also receive up to 16 weeks of NRT shipped directly to their home. The program is available through a partnership with Roswell Park Tobacco Cessation Services Division. NRT does not duplicate any Part D benefit. For more information, please visit</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p>\$20 copayment per date of service for Medicare-covered SET services.</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Our plan covers urgently needed care anywhere in the world.</p>	<p>\$30 copayment for each urgently needed care visit at any network urgent care facility or at an out-of-network facility when a network facility is unavailable or inaccessible.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Eyewear (glasses, prescription sunglasses, lenses, frames, contacts) and eyeglass repair <p>Eyewear can be obtained from any optical vendor. You are reimbursed for a portion of your total yearly expenses for eyewear and eyeglass repair. Submit your receipt and proof of payment to CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206.</p>	<p>\$20 copayment for exams to diagnose and treat diseases and conditions of the eye.</p> <p>No copayment for Medicare-covered glaucoma screenings.</p> <p>20% of the allowed fee for each Medicare-covered item, including one pair of eyeglasses or contact lenses after each cataract surgery.</p> <p>Corrective lenses include one pair of eyeglasses with standard frames or one set of standard contact lenses.</p> <p>\$20 copayment for annual routine eye exam.</p> <p>\$100 annual allowance toward covered eyewear purchases.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Weight management program</p> <p>Members who participate in a weight loss program with a preferred vendor are eligible for a once per plan year reimbursement of up to \$75 for a completed program.</p> <p>Conditions for Reimbursement:</p> <ul style="list-style-type: none"> • The reimbursement is only allowed once per plan year. • Members must attend and pay for the weight loss program. • Members must have the weight loss program instructor sign a confirmation form, attesting that the program has been completed. • Members must send the original copy of the completed rebate form to: <p>CDPHP Claims Dept. P.O. Box 66602 Albany, NY 12206-6602</p> <p>The completed form should not be photocopied; the reimbursement is nontransferable.</p>	<p>No copayment.</p>
<p> “Welcome to Medicare” preventive visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 3 What services are not covered by the plan?****Section 3.1 Services we do *not* cover (exclusions)**

This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		<p style="text-align: center;">✓</p> <p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • 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.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance).		✓ Except when medically necessary.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
		✓
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Monthly gym memberships		✓ No-cost gym memberships are available to all members through our Senior Fit® program at designated locations. Please see the Health and Wellness Education Programs section in the Medical Benefits Chart for more information.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	✓	Please see Chapter 4, Section 2 for benefit details.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	✓	Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Please see Chapter 4, Section 2 for benefit details.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veteran Affairs (VA) facilities		<p style="text-align: center;">✓</p> When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Supportive devices for the feet		<p style="text-align: center;">✓</p> Orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity		<p style="text-align: center;">✓</p> Except when it is considered medically necessary and covered under Original Medicare.
Wigs and cranial prosthesis	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

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

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

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Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1 If you pay our plan's share of the cost of your covered services, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

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

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.3.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

Sometimes a person’s enrollment in the plan is retroactive. (Retroactive 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 after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

Section 2.1	How and where to send us your request for payment
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Send us your request for payment, along with your bill and documentation of any payment you have made. It’s a good idea to make a copy of your bill and receipts for your records.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

Mail your request for payment together with any bills or receipts to us at this address:

CDPHP
Attn: Medicare Claims
P.O. Box 66602
Albany, NY 12206

You may also call our plan to request payment. For details, go to Chapter 2, Section 1 and look for the section called, *Where to send a request that asks us to pay for our share of the cost for medical care you have received.*

You must submit your claim to us within 12 months of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1	We check to see whether we should cover the service and how much we owe
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

Section 3.2	If we tell you that we will not pay for all or part of the medical care, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to section 5.3 to learn how to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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Chapter 6. Your rights and responsibilities

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

Section 1.1	We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact the Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with CDPHP, 500 Patroon Creek Blvd., Albany, NY 12206-1057, <https://www.cdphp.com>, (518) 641-3950 or 1-888-248-6522. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact customer service at (518) 641-3950 or 1-888-248-6522 for additional information. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.

Section 1.2	We must ensure that you get timely access to your covered services
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As a member of our plan, you have the right to choose a Primary Care Provider in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Chapter 6. Your rights and responsibilities

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.
- The laws that protect your privacy give you rights related to getting 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.
- In most situations, if we 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 first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

Chapter 6. Your rights and responsibilities

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.4	We must give you information about the plan, its network of providers, and your covered services
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As a member of CDPHP Group Medicare (HMO) you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
 - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Directory of Plan Practitioners and Providers.
 - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at <https://www.cdphp.com>.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider or pharmacy.

Chapter 6. Your rights and responsibilities

- If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

Chapter 6. Your rights and responsibilities

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

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

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

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

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

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

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

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

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

Chapter 6. Your rights and responsibilities

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with New York State Department of Health, Office of Professional Medical Conduct, at (518) 402-0836 or 1-800-663-6114. They are available Monday through Friday, 9 a.m. to 5 p.m. Or, visit <https://www.nyhealth.gov/professionals/doctors/conduct/> to download a complaint form.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Chapter 6. Your rights and responsibilities

Section 1.8 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

Chapter 6. Your rights and responsibilities

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) *or* coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
 - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

Chapter 6. Your rights and responsibilities

- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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(coverage decisions, appeals, complaints)**

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**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****BACKGROUND****SECTION 1 Introduction****Section 1.1 What to do if you have a problem or concern**

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

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

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**SECTION 2 You can get help from government organizations that
are not connected with us**

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<https://www.medicare.gov>).

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

**Section 3.1 Should you use the process for coverage decisions and
appeals? Or should you use the process for making
complaints?**

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

To figure out which part of this chapter will help with your specific problem or concern,
START HERE

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care are covered or not, the way in which they are covered, and problems related to payment for medical care.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and appeals.”**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
 - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at <https://www.cdphp.com>.
The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 7** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**SECTION 5 Your medical care: How to ask for a coverage
decision or make an appeal**



Have you read Section 4 of this chapter (A guide to “the basics” of coverage decisions and appeals)? If not, you may want to read it before you start this section.

Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
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This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rule for Part B prescription drugs are different from the rule for medical items and services.

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

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

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.

For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination**.”

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “**fast coverage decision**.”

Legal Terms

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request .

- **However**, for a request for a **medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours if your request is for medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
 - **However**, for a request for a **medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast coverage decision”

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard coverage decision”

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
 - For a request for a medical item or service we can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
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Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at <https://www.cdphp.com>. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care*).

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms

A “fast appeal” is also called an “ expedited reconsideration. ”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast appeal”

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to do so.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an . Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an . Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your level 2 appeal **within 7 calendar days** of when it reviews your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receives the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If 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 on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan’s coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)

- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is *yes* at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also 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 has been decided, your doctor or the hospital staff will let you know.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can **“request an immediate review.”** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 3. Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

Section 6.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and . (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 6.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision

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they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.

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- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date. If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate Appeal*

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast review” of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

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Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

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Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1	<i>This section is about three services only:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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This section is about the following types of care *only*:

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2	We will tell you in advance when your coverage will be ending
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

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Legal Terms

In telling you what you can do, the written notice is telling how you can request a “**fast-track appeal.**” Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

2. You sign the written notice to show that you received it.

- You or someone who is acting on your behalf the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.***What is the Quality Improvement Organization?***

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received 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, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal noon of the day the
- If you miss the deadline for contacting the Quality Improvement Organizatio

Step 2: The Quality Improvement Organization conducts an independent review of your case.***What happens during this review?***

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

This notice of explanation is called the “Detailed Explanation of Non-Coverage.”

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 to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. 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 another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 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 that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast review” of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get 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, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government

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agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal**, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1	levels 3, 4 and 5 for Medical Service
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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(coverage decisions, appeals, complaints)**

Level 3 Appeal: A judge (called 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** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice

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you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Complaint	Example
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
<p>Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.</p> <p>However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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Section 9.2 The formal name for “making a complaint” is “filing a grievance”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call (518) 641-3950 or 1-888-248-6522. If your complaint involves a behavioral health service, or alcohol or substance abuse services, please call us at 1-888-320-9584. TTY/TDD users should call 711. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may write to us at CDPHP, Attn: Medicare Appeals and Grievances, P.O. Box 66209, Albany, NY 12206. A designated representative of CDPHP will coordinate the review and investigation of your grievance. When the grievance pertains to clinical matters, qualified personnel including, but not limited to, one or more licensed, certified, or registered health care professionals will review the grievance. CDPHP will provide to you, or your designee, a written decision concerning the grievance within 30 calendar days after receipt of the grievance. Please note that we may extend the time frame for rendering a decision up to 14 days if you request an extension, or if CDPHP justifies the need for additional information and documents how the delay is in the interest of the member. CDPHP will immediately provide written notification of the delay and the reasons for the delay.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**

Legal Terms

What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - 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.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4 of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about CDPHP Group Medicare (HMO) directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in CDPHP Group Medicare (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

It is important that you contact your employer's benefits administrator with questions about disenrolling from CDPHP Group Medicare (HMO).

SECTION 2 Until your membership ends, you must keep getting your medical services through our plan

Section 2.1 Until your membership ends, you are still a member of our plan

If you leave CDPHP Group Medicare (HMO) it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

Chapter 8. Ending your membership in the plan

SECTION 3 CDPHP Group Medicare (HMO) must end your membership in the plan in certain situations

Section 3.1 When must we end your membership in the plan?
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CDPHP Group Medicare (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 60 days.
 - We must notify you in writing that you have 60 days to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Chapter 8. Ending your membership in the plan

Section 3.2 We cannot ask you to leave our plan for any reason related to your health

CDPHP Group Medicare (HMO) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 3.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

Chapter 9. Legal notices

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Chapter 9. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Capital District Physicians' Health Plan, Inc. (CDPHP) complies with applicable federal civil-rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters

Chapter 9. Legal notices

- Information written in other languages

If you need these services, contact the CDPHP Civil Rights Coordinator.

CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), fax (518) 641-3401. You can file a grievance by mail or fax, or electronically at <https://www.cdphp.com/customer-support/email-cdphp>. If you need help filing a grievance, the CDPHP Civil Rights Coordinator is available to help you. You can also file a civil-rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20211, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, CDPHP Group Medicare (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of CDPHP Group Medicare (HMO) you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and 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. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%).

Complaint - The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Chapter 10. Definitions of important words

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, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as 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.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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 10. Definitions of important words

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Enhanced Primary Care Physician – CDPHP network physicians who are with a practice that is committed to providing better, more comprehensive care by expanding office hours, spending more time with patients, and focusing on a higher-quality overall experience.

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.

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.

Grievance - A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide 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). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, 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.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums do not count toward the maximum out-of-

Chapter 10. Definitions of important words

pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

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). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare or make changes to your Part D coverage. The Open Enrollment Period is from January 1 until March 31, 2021.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Chapter 10. Definitions of important words

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and

Chapter 10. Definitions of important words

living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get services that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Chapter 10. Definitions of important words

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

CDPHP Group Medicare (HMO) Member Services

Method	Member Services – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Member Services also has free language interpreter services available for non-English Speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057 <u>Error! Hyperlink reference not valid.</u>
WEBSITE	https://www.cdphp.com

Health Insurance Information Counseling & Assistance Program (HIICAP) (New York State 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	Contact Information
CALL/TTY/WRITE	County-specific phone numbers are listed in Chapter 2, Section 3 of the <i>Evidence of Coverage</i>
WEBSITE	https://aging.ny.gov

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A plan for life.

Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Blvd., Albany, NY 12206-1057
(518) 641-3950 or 1-888-248-6522
<https://www.cdphp.com>

January 1 – December 31, 2021

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of CDPHP Group Medicare Rx (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2021. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, CDPHP Group Medicare Rx (HMO), is offered by Capital District Physicians' Health Plan, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Capital District Physicians' Health Plan, Inc. When it says "plan" or "our plan," it means CDPHP Group Medicare Rx (HMO)).

CDPHP Medicare Advantage is an HMO plan with a Medicare contract. Enrollment in CDPHP Medicare Advantage depends on contract renewal.

Please contact our Member Services number at (518) 641-3950 or 1-888-248-6522 for additional information. (TTY users should call 711). Hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are Monday – Friday, 8 a.m. – 8 p.m. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.

Member Services has free language-interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

This information is available in different formats, including large print. Please call Member Services if you need plan information in another format.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2022.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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2021 Evidence of Coverage

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CHAPTER 1

Getting started as a member

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Chapter 1. Getting started as a member**SECTION 1 Introduction****Section 1.1 You are enrolled in CDPHP Group Medicare Rx (HMO), which is a Medicare HMO**

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, CDPHP Group Medicare Rx (HMO).

There are different types of Medicare health plans. CDPHP Group Medicare Rx (HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families> for more information.

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

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of CDPHP Group Medicare Rx (HMO).

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

If you are confused or concerned or just have a question, please contact our plan's Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.3 Legal information about the *Evidence of Coverage***It's part of our contract with you**

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

The contract is in effect for months in which you are enrolled in CDPHP Group Medicare Rx (HMO) between January 1, 2021 and December 31, 2021.

Chapter 1. Getting started as a member

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of CDPHP Group Medicare Rx (HMO) after December 31, 2021. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2021.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve CDPHP Group Medicare Rx (HMO) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer the plan and Medicare renews its approval of the plan.

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for CDPHP Group Medicare Rx (HMO)

Although Medicare is a Federal program, CDPHP Group Medicare Rx (HMO) *is* available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in New York state: Albany, Broome, Chenango, Clinton, Columbia, Delaware, Dutchess, Essex, Franklin, Fulton, Greene, Hamilton, Herkimer, Madison, Montgomery, Oneida,

Chapter 1. Getting started as a member

Orange, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Tioga, Ulster, Warren, and Washington.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?**Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs**

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



Use this medical card at a physician's office for medical services and at the pharmacy for Part B-covered drugs.

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Use this prescription drug card at the pharmacy for Part D-covered drugs.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your CDPHP Group Medicare Rx (HMO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2 The Provider Directory: Your guide to all providers in the plan's network

The *Provider Directory* lists our network providers.

What are "network providers"?

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 any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at <https://www.cdphp.com>.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which CDPHP Medicare Group Rx (HMO)

Chapter 1. Getting started as a member

authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. For the most up-to-date provider information, please visit <https://findadoc.cdphp.com> or download the My CDPHP app to your smartphone. Call the Member Services department if you want more information on a doctor's qualifications, such as where he or she completed medical school or residency, or if he or she is board-certified.

Section 3.3 The *Pharmacy Directory*: Your guide to pharmacies in our network

What are “network pharmacies”?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the Pharmacy Directory to find the network pharmacy you want to use. There are changes to our network of pharmacies for next year. An updated Pharmacy Directory is located on our website at <https://www.cdphp.com>. You may also call Member Services for updated provider information or to ask us to mail you a Pharmacy Directory. **Please review the 2021 Pharmacy Directory to see which pharmacies are in our network.**

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at <https://www.cdphp.com>. Or, you can contact CVS Caremark Customer Care at 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

Section 3.4 The plan's List of Covered Drugs (*Formulary*)

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

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

We will provide you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (<https://www.cdphp.com>) or call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 1. Getting started as a member**Section 3.5 The *Part D Explanation of Benefits* (the “Part D EOB”): Reports with a summary of payments made for your Part D prescription drugs**

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Part D Explanation of Benefits* (or the “Part D EOB”).

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for CDPHP Group Medicare Rx (HMO)**Section 4.1 How much is your plan premium?**

Your coverage is provided through a contract with your current employer or former employer or union. Please contact the employer’s or union’s benefits administrator for information about your plan premium.

What happens if your employer group or union doesn’t pay its plan premiums, or doesn’t pay them on time?

If your employer group’s or union’s coverage through CDPHP is terminated due to nonpayment of premiums or any other reason, CDPHP will provide you with written notice of the termination. You then will have Original Medicare coverage. You may be eligible to enroll in any individual Medicare plan offered by CDPHP or another plan provider. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less

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

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

Chapter 1. Getting started as a member

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a Part D **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) For these members, the Part D late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their Part D late enrollment penalty.
 - If you are required to pay the Part D late enrollment penalty, the cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. Chapter 1, Section 5 explains the Part D late enrollment penalty.
 - If you have a Part D late enrollment penalty and do not pay it, you could be disenrolled from the plan.

SECTION 5 Do you have to pay the Part D "late enrollment penalty"?

Section 5.1 What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in CDPHP Group Medicare Rx (HMO), we let you know the amount of the penalty.

The Part D late enrollment penalty is considered part of your plan premium. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 5.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription

Chapter 1. Getting started as a member

drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2021, this average premium amount is \$32.74
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$32.74, which equals \$4.58. This rounds to \$4.60. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

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

Section 5.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the Part D late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage.**" Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
 - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Chapter 1. Getting started as a member

- For additional information about creditable coverage, please look in your *Medicare & You 2021 Handbook* or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 5.4 What can you do if you disagree about your Part D late enrollment penalty?

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. If you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

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

SECTION 6 Do you have to pay an extra Part D amount because of your income?

Section 6.1 Who pays an extra Part D amount because of income?

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

Section 6.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium. For more information on the extra amount you may have to pay based on your income, visit <https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html>.

Chapter 1. Getting started as a member

Section 6.3 What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 6.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required by law to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

SECTION 7 More information about your monthly premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. Most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

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.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 1, Section 6 of this booklet. You can also visit <https://www.medicare.gov> on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2021* gives information about the Medicare premiums in the section called "2021 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2021* from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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Section 7.1 Can we change your monthly plan premium during the year?

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

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

SECTION 8 Please keep your plan membership record up to date

Section 8.1 How to help make sure that we have accurate information about you

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Services (phone numbers are printed on the back cover of this booklet). Or, log into <https://www.cdphp.com>.

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

Chapter 1. Getting started as a member

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 10 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).

SECTION 9 We protect the privacy of your personal health information

Section 9.1 We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.3 of this booklet.

SECTION 10 How other insurance works with our plan

Section 10.1 Which plan pays first when you have other insurance?

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

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

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

Chapter 1. Getting started as a member

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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SECTION 1 CDPHP Group Medicare Rx (HMO) contacts (how to contact us, including how to reach Member Services at the plan)

How to contact our plan's Member Services

For assistance with claims, billing, or member card questions, please call or write to CDPHP Group Medicare Rx (HMO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057 info@cdphp.com
WEBSITE	https://www.cdphp.com

How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services and prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your medical care and Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Chapter 2. Important phone numbers and resources

Method	Coverage Decisions, Appeals, or Complaints For Medical Care and Part D Prescription Drugs– Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057 info@cdphp.com
WEBSITE	https://www.cdphp.com
MEDICARE WEBSITE	You can submit a complaint about CDPHP Group Medicare Rx (HMO) directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care and Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Chapter 2. Important phone numbers and resources

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

Method	Payment Requests – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Calls to this number are free.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	Medical and Dental Claims: 500 Patroon Creek Blvd., Albany, NY 12206-1057 Pharmacy Claims: CVS Caremark Part D Services, LLC, Attn: Medicare Paper Claims, P.O. Box 52066, Phoenix, AZ 85072-2066
WEBSITE	https://www.cdphp.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.

Chapter 2. Important phone numbers and resources

Method	Medicare – Contact Information
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>https://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.</p> <p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about CDPHP Group Medicare Rx (HMO):</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about CDPHP Group Medicare Rx (HMO) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

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

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

Chapter 2. Important phone numbers and resources

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

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

Method	Health Insurance Information Counseling & Assistance Program (New York State SHIP) – Contact Information
CALL or WRITE	<p>Albany County: Department for Aging, 162 Washington Ave., Albany, NY 12210, (518) 447-7198</p> <p>Broome County: Broome County Office Building, 60 Hawley St., 4th Floor, P.O. BOX 1766, Binghamton, NY 13902-1766, (607) 778-2411</p> <p>Chenango County: County Office Building, 5 Court St., Norwich, NY 13815-1794, (607) 337 1770</p> <p>Clinton County: 135 Margaret St., Suite 105, Plattsburgh, NY 12901, (518) 565-4560</p> <p>Columbia County: Office for the Aging, 325 Columbia St., Suite 231, Hudson, NY 12534, (518) 828-4258</p> <p>Delaware County: Office for the Aging, 97 Main St., Suite 2, Delhi, NY 13753, (607) 746-6333</p> <p>Dutchess County: Dutchess County Office for the Aging, 27 High Street, Poughkeepsie, NY 12601-1962, (845) 486-2555</p> <p>Essex County: Office for the Aging, P.O. Box 217, 132 Water St., Elizabethtown, NY 12932-0217, (518) 873-3695</p> <p>Franklin County: 355 W. Main St., 3rd Floor, Malone, NY 12953, (518) 481-1635</p> <p>Fulton County: Office for Aging, 19 N. William St., Johnstown, NY 12095-2534, (518) 736-5650</p> <p>Greene County: Department for the Aging, 411 Main St., Catskill, NY 12414, (518) 719-3555</p> <p>Hamilton County: Warren/Hamilton Counties Office for the Aging, Human Services Building, 1340 State Route 9, Lake George, NY 12845, (518) 761-6347</p> <p>Herkimer County: Office for the Aging, 109 Mary St., Suite 1101, Herkimer, NY 13350-2924, (315) 867-1195</p> <p>Madison County: Office for the Aging, 138 Dominick Bruno Blvd., Canastota, NY 13032, (315) 697-5700</p> <p>Montgomery County: Office for the Aging, 135 Guy Park Ave., Amsterdam, NY 12010, (518) 843-2300 Ext. 229</p> <p>Oneida County: Office for Aging and Continuing Care, 300 W. Dominick St., Rome, NY 13440, and 800 Park Ave., Utica, NY 13501, (315) 798-5456</p> <p>Orange County: Orange County Office for the Aging, 40 Matthews Street, 3rd Floor - Suite 305, Goshen, NY 10924, (845) 615-3700</p> <p>Otsego County: Meadows Office Complex, Suite 5, 140 County Highway 33W, Cooperstown, NY 13326, (607) 547-4232</p> <p>Rensselaer County: Unified Family Services, Department for the Aging, 1600 Seventh Ave., 4th floor, Troy, NY 12180-3798, (518) 270-2730</p> <p>Saratoga County: Office for the Aging, 152 West High St., Ballston Spa, NY 12021-3528, (518) 884-4100</p>

Chapter 2. Important phone numbers and resources

Schenectady County: Department of Senior and Long Term Care Services, Schaffer Heights, 107 Nott Terrace, Schenectady, NY 12308, (518) 382-8481

Schoharie County: Office for the Aging, 113 Park Place, Suite 3, Schoharie, NY 12157, (518) 295-2001

Tioga County: Tioga Opportunities, Inc. – Aging Services, 9 Sheldon Guile Blvd., Owego, NY 13827, (607) 687-4120

Ulster County: Ulster County Office for the Aging, 1003 Development Court, Kingston, NY 12401, (845) 340-3456

Warren County: Warren/Hamilton Counties Office for the Aging, Human Services Building, 1340 State Route 9, Lake George, NY 12845, (518) 761-6347

Washington County: Washington County CARES, Office for Aging and Disability Resources, 383 Broadway, Fort Edward, NY 12828, (518) 746-2420

WEBSITE You can learn more about HIICAP by visiting their website (<https://www.aging.ny.gov>).

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta (New York's Quality Improvement Organization)
CALL	1-866-815-5440
TTY	1-866-868-2289 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701

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Method	Livanta (New York's Quality Improvement Organization)
WEBSITE	https://www.BFCCQIOAREA1.com

SECTION 5 Social Security

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

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid
 (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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.

Chapter 2. Important phone numbers and resources

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

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

To find out more about Medicaid and its programs, contact the New York State Medicaid Office.

Method	New York State Medicaid – Contact Information
CALL	1-800-541-2831
WRITE	New York State Department of Health Corning Tower Empire State Plaza Albany, NY 12237
WEBSITE	https://www.health.ny.gov/health_care/medicaid

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

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, yearly deductible, and prescription copayments. This “Extra Help” also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day/7 days a week;

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- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

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

- If you think you qualify for extra help with your prescription drug costs, but you don’t have or can’t find proof, please contact the plan. You also can read the CMS Best Available Evidence Policy at https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Best_Available_Evidence_Policy.html.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn’t collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D members who have reached the coverage gap and are not receiving “Extra Help.” For brand name drugs, the 70% discount provided by manufacturers excludes any dispensing fee for costs in the gap. Members pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Part D Explanation of Benefits (Part D EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 75% of the price for generic drugs and you pay the remaining 25% of the price. For generic drugs, the amount paid by the plan (75%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

Chapter 2. Important phone numbers and resources

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than “Extra Help”), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

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

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance New York AIDS Drug Assistance Program (ADAP). Note: To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. (518) 459-1641 or 1-800-542-2437 (in-state only).

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call (518) 459-1641 or 1-800-542-2437 (in-state only).

What if you get “Extra Help” from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get “Extra Help,” you already get coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Part D Explanation of Benefits* (Part D EOB) notice. If the discount doesn’t appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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

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

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Method	Elderly Pharmaceutical Insurance Coverage (EPIC) (New York's State Pharmaceutical Assistance Program) – Contact Information
CALL	1-800-332-3742
TTY	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	P.O. Box 15018, Albany, NY 12212-5018
WEBSITE	https://www.health.state.ny.us/health_care/epic

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press “1,” you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	https://secure.rrb.gov/

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can

Chapter 2. Important phone numbers and resources

ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services**Chapter 3. Using the plan's coverage for your medical services**

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Chapter 3. Using the plan's coverage for your medical services

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

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

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

Section 1.1 What are “network providers” and “covered services”?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

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

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

As a Medicare health plan, CDPHP Group Medicare Rx (HMO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

CDPHP Group Medicare Rx (HMO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered 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.

Chapter 3. Using the plan's coverage for your medical services

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
 - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
 - The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

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

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care
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What is a "PCP" and what does the PCP do for you?

When you become a member of our plan, you must choose a PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. A PCP can also assist with coordinating the rest of the covered services you need, including obtaining prior authorization (PA), when applicable.

Chapter 3. Using the plan's coverage for your medical services

What is Enhanced Primary Care?

Enhanced Primary Care is a partnership between CDPHP and many network physicians who are committed to quality and spend more time with patients, offer expanded office hours, and deliver better, more comprehensive care.

To find an Enhanced Primary Care physician near you, use the Find-A-Doc search tool at <https://findadoc.cdphp.com>. Select “Enhanced Primary Care” in the “Select a Specialty” drop-down menu to view all Enhanced Primary Care physicians.

Once you access the list, look for your current physician to see if he or she participates in the Enhanced Primary Care program.

How do you choose your PCP?

When selecting a PCP, you should select a doctor who specializes in internal medicine, family practice, or general practice as listed in the Directory of Plan Practitioners and Providers. Women may also receive care from an obstetrician/gynecologist without an authorization from their PCP.

Changing your PCP

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

Changing your PCP is as easy as calling Member Services or logging into <https://www.cdphp.com>. If there is a particular network specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. Member Services will help make sure that you can continue with the specialty care and other services you have been getting. They will confirm that the PCP you select is accepting new patients. Member Services will change your membership record to show the name of your new PCP. The change will be effective immediately upon receipt of the request.

Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?
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You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.

Chapter 3. Using the plan's coverage for your medical services

- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (e.g., when you are temporarily outside of the plan's service area)
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)

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

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

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

Your PCP will provide most of your routine or basic health care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes 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 network providers about your care and how it is going.

You are not required to obtain or submit a referral slip. Your PCP can send you to another network provider without filing any special paperwork or getting a referral number. Instead, when visiting a network specialist for referred care, be sure to give them your PCP's information.

Your PCP or treating provider is responsible for contacting CDPHP to request prior authorization (PA) for services denoted as requiring PA in the Medical Benefits Chart (Chapter 4, Section 2.1). In the event that the PA request is submitted by someone other than your treating provider, CDPHP may contact the treating provider for informational purposes prior to rendering a decision regarding the requested services.

Please note that certain services, including inpatient hospitalization, still need prior authorization by our plan. For a complete list of benefits requiring prior authorization, please see the Medical Benefits Chart in Chapter 4 of this booklet.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan,

Chapter 3. Using the plan's coverage for your medical services

but if your doctor or specialist does leave your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out your doctor or specialist is leaving your plan, please contact us by calling Member Services at (518) 641-3950 or 1-888-248-6522, so we can assist you in finding a new provider and managing your care.

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

If you are outside the plan's service area and have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation, our plan covers urgently needed care that you get from any provider. Emergency care is always covered. See Section 3 below for more information about emergency and urgently needed care.

In addition, plans must cover dialysis services for ESRD enrollees who have traveled outside the plan's service area and are not able to access contracted ESRD providers.

All other routine medical care that you receive from a provider who is not part of our network requires prior authorization from our plan. If you need to receive routine medical care from an out-of-network provider, contact Member Services to obtain prior authorization.

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

Section 3.1 Getting care if you have a medical emergency**What is a "medical emergency" and what should you do if you have one?**

A "medical emergency" is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require

Chapter 3. Using the plan's coverage for your medical services

immediate medical attention to prevent loss of life, 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.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services at (518) 641-3950 or 1-888-248-6522 Monday through Friday from 8 a.m. to 8 p.m. TTY users should call 711.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

In addition, you are covered worldwide for medically necessary emergency care. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.

Chapter 3. Using the plan's coverage for your medical services

- – *or* – The additional care you get is considered “urgently needed services” and you follow the rules for getting this urgently needed services (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for services**What are “urgently needed services”?**

“Urgently needed services” are non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

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.

In most situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable (e.g., if you need care after normal business hours), or contracted providers are inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

You can contact your primary care physician for instructions and advice for urgently needed care. In addition, CDPHP has the following resources available to assist you:

- We cover online internet consultations with providers who participate in the CDPHP telemedicine program for medical conditions that are not emergency conditions. Our telemedicine program allows members to communicate with providers through two-way video, and can be easily accessed through our member site at <https://www.cdphp.com>.
- Use our web tool, <https://findadoc.cdphp.com>, to locate urgent care centers near you.
- Find an urgent care center via our My CDPHP app. Visit <https://www.cdphp.com/mobile> to download the app to your smartphone.

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider.

Chapter 3. Using the plan's coverage for your medical services

Our plan covers worldwide emergency and urgent services outside the United States.

Our plan does not cover any other non-emergency services if you receive the care outside of the United States.

Section 3.3 Getting care during a disaster

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

Please visit the following website: <https://www.cdphp.com> for information on how to obtain needed care during a disaster.

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

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

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

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

Section 4.2 If services are not covered by our plan, you must pay the full cost

CDPHP Group Medicare Rx (HMO) covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 3. Using the plan's coverage for your medical services

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Expenses incurred after a benefit has been exhausted do not apply toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a “clinical research study”?

A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare *first* needs to approve the research study. If you participate in a study that Medicare *has not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

Chapter 3. Using the plan's coverage for your medical services

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

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

Chapter 3. Using the plan's coverage for your medical services

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<https://www.medicare.gov>).

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.

Chapter 3. Using the plan's coverage for your medical services

- – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

If you get care from a religious non-medical health care institution, all inpatient hospital coverage limits apply. For more information, please refer to “Inpatient Hospital Care” in the benefits chart in Chapter 4 on pages 61-62.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of CDPHP Group Medicare Rx (HMO), however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

SECTION 8

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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Chapter 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 1 Understanding your out-of-pocket costs for covered services**

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of CDPHP Group Medicare Rx (HMO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

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

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of CDPHP Group Medicare Rx (HMO), the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2021 is \$2,500. The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. If you reach the maximum out-of-pocket amount of \$2,500, you will not have to pay any out-of-pocket costs for the rest of the year for in-network 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).

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Section 1.3 Our plan does not allow providers to “balance bill” you**

As a member of CDPHP Group Medicare Rx (HMO), an important protection for you is you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

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

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services CDPHP Group Medicare Rx (HMO) covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

- Your services (including medical care, services, supplies, and equipment) *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.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan’s network. This is called giving you a “referral.” Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called “prior authorization”) from us. Covered services that need approval in advance are marked in the Medical Benefits Chart by an asterisk.


Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021 Handbook*. View it online at <https://www.medicare.gov> or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2021, either Medicare or our plan will cover those services.



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

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
Ambulance services* <ul style="list-style-type: none">• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan.• Non-emergency transportation by ambulance is appropriate if it is 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.	\$75 copayment for each one-way trip for Medicare-covered ambulance benefits. Prior authorization required for air ambulance services. Medically necessary interfacility transfers (not at patient's request) are not subject to copayment.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Annual wellness visit**

If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months.

Note: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.

There is no coinsurance, copayment, or deductible for the annual wellness visit.

**Bone mass measurement**

For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.




**Breast cancer screening (mammograms)**

Covered services include:

- One baseline mammogram between the ages of 35 and 39
- One screening mammogram every 12 months for women age 40 and older
- Clinical breast exams once every 24 months

There is no coinsurance, copayment, or deductible for covered screening mammograms.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.</p>	
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>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.</p>	<p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p>	<p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 	<p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Chiropractic services**

Covered services include:


- We cover only manual manipulation of the spine to correct subluxation

\$20 copayment to correct subluxation for each Medicare-covered visit.


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months <p>One of the following every 12 months:</p> <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) <p>DNA based colorectal screening every 3 years</p> <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy 	<p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. We cover:</p> <p>Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.</p>	<p>\$20 copayment for Medicare-covered non-routine dental care.</p> <p>You are reimbursed up to \$150 for routine, preventive dental benefits every year. Submit your receipt and proof of payment to CDPHP MEDICARE CLAIMS, P.O. BOX 66602, ALBANY, NY 12206. This benefit may be used at any dental provider, in or out of network.</p> <p>Fluoride treatments are not covered.</p> <p>NOTE: Periodontal cleanings are not considered routine and are excluded from coverage.</p>
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.</p>	<p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes screening</p> <p>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <ul style="list-style-type: none"> • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions 	<p>No copayment for blood glucose monitors (limited to one per year) and blood glucose test strips (limited to a 90-day supply) made by Ascensia Diabetes Care and purchased at a network pharmacy; if you use a monitor or test strips made by a different manufacturer, contact Member Services for more information or to request an exception.</p> <p>\$10 or 20% of the Medicare-allowed fee (whichever is less) for up to a 90-day supply of each diabetic supply covered under Part B (including lancets, glucose control solutions, insulin pump supplies, reservoirs).</p> <p>20% of the Medicare-allowed fee for each diabetic monitoring or DME item covered under Part B (including insulin pumps, therapeutic custom molded shoes and inserts one pair per calendar year, etc.)</p> <p>No copayment for Medicare-covered diabetes self-management training.</p> <p>Diabetic pharmaceuticals (including oral agents, insulin preparations, etc.) are covered under the prescription drug portion of the CDPHP Group Medicare Rx (HMO) plan.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment (DME) and related supplies* (For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special-order it for you.</p> <p>*Prior authorization is required for:</p> <ul style="list-style-type: none"> • Rentals of each covered item. • Purchases of each covered item totaling a \$1,000 or more. • Repairs totaling \$1,000 or more. • Adjustments and/or replacement of DME in accordance with Medicare standards. 	<p>20% of the Medicare-allowed fee for each Medicare-covered item.</p> <p>Coinsurance is based on the Medicare-allowed fee, which may be less than the billed charge.</p>
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Our plan covers emergency care anywhere in the world.</p>	<p>\$75 copayment for Medicare-covered emergency room visits. Copayment is waived if you are admitted to the hospital within 24 hours for the same condition.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan, and your cost is the cost-sharing you would pay at a network hospital.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)


Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs</p> <p>We cover a variety of services designed to help keep you healthy. Call Member Services at (518) 641-3950 or 1-888-248-6522 for more details.</p> <p>Programs include, but are not limited to:</p> <ul style="list-style-type: none">•	<p>There is no coinsurance, copayment, or deductible for health and wellness education programs.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Hearing services**

Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.

\$20 copayment for one annual routine hearing exam.


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies 	<p>No copayment.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>When you 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 CDPHP Group Medicare Rx (HMO).</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Hospice care (continued)</p> <p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p> <p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none">• If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services• If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) <p><u>For services that are covered by CDPHP Group Medicare Rx (HMO) but are not covered by Medicare Part A or B:</u> CDPHP Group Medicare Rx (HMO) will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.</p> <p><u>For drugs that may be covered by the plan's Part D benefit:</u> Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (<i>What if you're in Medicare-certified hospice</i>).</p> <p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.</p>
<p>•</p>	

Chapter 4. Medical Benefits Chart (what is covered and 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 are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.

Covered services include but are not limited to:

- Semi-private room (or a private room if medically necessary)
- Meals including special diets
- Regular nursing services
- Costs of special care units (such as intensive care or coronary care units)
- Drugs and medications
- Lab tests
- X-rays and other radiology services
- Necessary surgical and medical supplies
- Use of appliances, such as wheelchairs
- Operating and recovery room costs
- Physical, occupational, and speech language therapy
- Inpatient substance abuse services

There is no copayment for inpatient hospital stays.

A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient hospital care (continued)</p> <ul style="list-style-type: none"> • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If CDPHP Group Medicare Rx (HMO) provides transplant services at a location outside the pattern of care for transplants in your community, and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used. • Physician services <p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay.</p> <ul style="list-style-type: none">• There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. Contact the plan for details about coverage in a psychiatric hospital beyond 190 days.• The 190-day lifetime limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	<p>There is no copayment for inpatient mental health care.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p>\$20 copayment applies for physician services.</p> <p>\$20 copayment for each Medicare-covered laboratory service. Copayment waived if provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.</p> <p>\$20 copayment for each Medicare-covered radiation therapy service.</p> <p>\$20 copayment per date of service for X-rays.</p> <p>\$40 copayment per date of service for each Medicare-covered advanced imaging study such as CT, CTA, MRI, MRA, or PET scans.</p> <p>No copayment for surgical dressings.</p> <p>20% of the Medicare-allowed fee for each Medicare-covered splint, cast, or device to reduce fractures or dislocations, orthotic and/or prosthetic.</p> <p>\$20 copayment for Medicare-covered physical, occupational, and speech therapy sessions.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

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

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Aranesp[®] and Retacrit) • Intravenous immune globulin for the home treatment of primary immune-deficiency diseases <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	<p>\$20 copayment per date of service for Medicare-covered Part B drugs administered in an outpatient or office setting.</p> <p>\$20 per prescription for Part B drugs purchased at a retail pharmacy.</p> <p>Prolia is subject to step therapy.</p> <p>Please note, an office visit or outpatient facility copayment will apply if additional services are rendered by your treating provider, depending on place of service billed by the provider.</p> <p>Medicare Part B covered prescriptions administered during an inpatient stay do not apply cost-sharing.</p> <p>No copayment for allergy injections.</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Opioid treatment program services</p> <p>Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include:</p> <ul style="list-style-type: none"> • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing <p>Medically necessary and reasonable services to treat addiction and abuse disorders, diagnosis, detoxification (removal of toxic substance), and outpatient rehabilitation services will be provided in case of substance abuse or addiction. To learn more, please call the CDPHP Behavioral Health Access Center during business hours at 1-888-320-9584</p>	<p>\$20 copayment for each Medicare-covered substance use counseling visit.</p> <p>\$20 copayment for each Medicare-covered individual and group therapy per date of service.</p> <p>\$20 copayment per Medicare-covered Part B drug. Multiple copayments may apply if additional services are rendered.</p> <p>\$20 copayment for each Medicare-covered laboratory service. Copayment waived if service provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Outpatient diagnostic tests and therapeutic services and supplies**

Covered services include, but are not limited to:

- X-rays
- Radiation (radium and isotope) therapy including technician materials and supplies.
- Advanced imaging studies (such as CT, CTA, MRI, MRA and PET scans).
- Cardiovascular monitoring services, including echocardiograms and cardiac stress tests.
- Surgical supplies, such as dressings
- Splints, casts and other devices used to reduce fractures and dislocations
- Laboratory tests
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used
- Other outpatient diagnostic tests

NOTE: Member cost-share is based upon the services rendered and the clinical setting in which they are performed. If services are billed by a hospital, see Outpatient Hospital Services for cost-share, as they may be higher.

\$20 copayment for each Medicare-covered X-ray or ultrasound.

\$20 copayment for each Medicare-covered radiation therapy service.

\$40 copayment for each Medicare-covered advanced imaging study.

\$20 copayment for cardiovascular monitoring services. This copay is in addition to applicable physician cost-sharing.

20% coinsurance of the Medicare-allowed fee for each Medicare-covered splint, cast, or device to reduce fractures and dislocations. No copayment for surgical supplies/dressings.

\$20 copayment for each Medicare-covered laboratory service. (Copayment waived if provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.)

No copayment for blood storage. Transfusion services rendered in

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient diagnostic tests and therapeutic services and supplies (continued)</p>	<p>outpatient department are subject to outpatient facility copayment.</p>
<p>Outpatient Hospital Observation</p> <p>Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.</p> <p>For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.</p> <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at _or by calling 1-800- MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.</p> <p>You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>\$75 copayment.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Outpatient hospital services**

We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but are not limited to:

- Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery
- Laboratory and diagnostic tests billed by the hospital
- Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- X-rays and other radiology services billed by the hospital
- Medical supplies such as splints and casts
- Certain drugs and biologicals that you can't give yourself

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at <https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

\$75 copayment for emergency room services.

\$20 copayment applies for outpatient clinic services. Multiple copayments may apply if additional services are rendered.

\$75 copayment for outpatient surgery billed by a hospital.

\$75 copayment for surgery at a freestanding ambulatory surgery center.

\$20 copayment for each Medicare-covered laboratory service. (Copayment waived if provided by preferred laboratory. You can identify preferred providers using Find-A-Doc, or a list of these providers will be furnished upon request.)

\$20 copayment for cardiovascular monitoring services.

There is no cost-share for Medicare-covered partial hospitalization services.

\$20 copayment for Medicare-covered X-rays and ultrasounds per date of service.

\$20 copayment for each Medicare-covered radiation therapy service.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services (continued)</p>	<p>\$40 copayment per date of service for each Medicare-covered advanced imaging study.</p> <p>20% coinsurance of the Medicare-allowed fee for each Medicare-covered item or device.</p> <p>No copayment for Medicare-covered preventive services as denoted in this Evidence of Coverage when provided in accordance with Medicare guidelines.</p> <p>Note: Additional testing or services ordered, rendered, or recommended during preventive visits will apply to the plan-defined cost-sharing, as they are outside the scope of preventive services.</p> <p>\$20 copayment per Medicare-covered Part B drug. Multiple copayments may apply if additional services are rendered.</p>
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p>\$20 copayment for each Medicare-covered date of service.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>\$20 copayment for Medicare-covered physical, occupational, and speech therapy sessions.</p>
<p>Outpatient substance abuse services</p> <p>Medically necessary and reasonable services to treat addiction and abuse disorders. Diagnosis, detoxification (removal of toxic substances), and outpatient rehabilitation services will be provided in case of substance abuse or addiction. To learn more, please call the CDPHP Behavioral Health Access Center during business hours at 1-888-320-9584</p>	<p>\$20 copayment for each Medicare-covered visit.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>\$75 copayment per date of service billed by an outpatient hospital or hospital-owned facility.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>There is no cost-share for partial hospitalization.</p> <p>Contact the Behavioral Health Access Center at 1-888-320-9584 or (518) 641-3600 for more information.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Physician/Practitioner services, including doctor's office visits**

Covered services include:

- Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location
- Consultation, diagnosis, and treatment by a specialist
- Basic hearing and balance exams performed by your specialist, if your doctor orders it to see if you need medical treatment
-

Physician copayments **do not** apply for outpatient hospital facility or ambulatory surgical center visits. You will be responsible for the applicable facility cost-sharing for those services.

\$20 copayment per Doctor On Demand telemedicine visit.

\$20 copayment per primary care physician visit.

\$20 specialist copayment per visit.

\$20 copayment for one annual routine hearing exam.


Copayments **do** apply for telehealth and telemedicine services, including anticoagulation management. Services billed by a primary care physician will apply a PCP copayment. Services billed by a specialist or anticoagulation management vendor will apply the specialist copayment.

\$20 copayment for second surgical opinion.

\$20 copayment for Medical-covered non-routine dental care visit.

No copayment for routine annual physical. No copayment for EKG when performed during a routine annual physical.



Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
	<p>No copayment for allergy injections.</p> <p>Please note, an office visit or outpatient facility copayment will apply if additional services are rendered by your treating provider, depending on place of service billed by the provider.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs 	<p>\$20 copayment per visit.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Prosthetic devices and related supplies*</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p> <p>*Prior authorization is required for:</p> <ul style="list-style-type: none">• Rentals of each covered item,• Purchases of each covered item totaling \$1,000 or more,• Repairs totaling \$1,000 or more, and• Adjustments and/or replacement of DME in accordance with Medicare standards.	<p>20% coinsurance of the Medicare-allowed fee, for each Medicare-covered item per date of service.</p> <p>All colostomy supplies are covered in full.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written 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.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the members must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>
<p>Services to treat kidney disease</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."</p>	<p>No copayment for kidney disease education services.</p> <p>\$20 copayment for in- and out-of-area renal dialysis.</p> <p>Out-of-area renal dialysis services are covered only in the United States.</p> <p>No copayment for self-dialysis training.</p> <p>See the "Inpatient Hospital Care" benefit for specific inpatient dialysis cost-sharing information.</p> <p>20% coinsurance of the allowed fee, for each Medicare-covered item for home dialysis.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Skilled nursing facility (SNF) care* (For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 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. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital 	<p>There is no cost-share for skilled nursing facility services.</p> <p>A "benefit period" starts the day you go into a hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. If you go into the hospital after one benefit period has ended, a new benefit period begins. You must pay the plan-defined cost-share for each benefit period. There is no limit to the number of benefit periods you can have.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>In addition, eligible CDPHP members have access to up to eight telephonic tobacco-cessation sessions with a quit coach per year. Members can also receive up to 16 weeks of NRT shipped directly to their home. The program is available through a partnership with Roswell Park Tobacco Cessation Services Division. NRT does not duplicate any Part D benefit. For more information, please visit</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>


Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Supervised Exercise Therapy (SET)</p> <p>SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment.</p> <p>Up to 36 sessions over a 12-week period are covered if the SET program requirements are met.</p> <p>The SET program must:</p> <ul style="list-style-type: none"> • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques <p>SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.</p>	<p>\$20 copayment per date of service for Medicare-covered SET services.</p>
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <p>Our plan covers urgently needed care anywhere in the world.</p>	<p>\$30 copayment for each urgently needed care visit at any network urgent care facility or at an out-of-network facility when a network facility is unavailable or inaccessible.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Eyewear (glasses, prescription sunglasses, lenses, frames, contacts) and eyeglass repair <p>Eyewear can be obtained from any optical vendor. You are reimbursed for a portion of your total yearly expenses for eyewear and eyeglass repair. Submit your receipt and proof of payment to CDPHP Medicare Claims, P.O. Box 66602, Albany, NY 12206.</p>	<p>\$20 copayment for exams to diagnose and treat diseases and conditions of the eye.</p> <p>No copayment for Medicare-covered glaucoma screenings.</p> <p>20% of the allowed fee for each Medicare-covered item, including one pair of eyeglasses or contact lenses after each cataract surgery. Corrective lenses include one pair of eyeglasses with standard frames or one set of standard contact lenses.</p> <p>\$20 copayment for annual routine eye exam.</p> <p>\$100 annual allowance toward covered eyewear purchases.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services that are covered for you	What you must pay when you get these services
<p>Weight Management Program</p> <p>Members who participate in a weight loss program with a preferred vendor are eligible for a once per Plan Year reimbursement of up to \$75 for a completed program.</p> <p>Conditions for Reimbursement:</p> <ul style="list-style-type: none"> • The reimbursement is only allowed once per Benefit Period. • Members must attend and pay for the weight loss program. • Members must have the weight loss program instructor sign a confirmation form, attesting that the program has been completed. • Members must send the original copy of the completed rebate form to: <p>CDPHP Claims Dept. P.O. Box 66602 Albany, NY 12206-6602</p> <p>The completed form should not be photocopied; the reimbursement is nontransferable.</p>	<p>No copayment.</p>
<p> “Welcome to Medicare” preventive visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 3 What services are not covered by the plan?****Section 3.1 Services we do *not* cover (exclusions)**

This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found 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 5.3 in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		✓
Cosmetic surgery or procedures		<div style="text-align: center;">✓</div> <ul style="list-style-type: none"> • 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 is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	

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Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		<p style="text-align: center;">✓</p> Except when medically necessary
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		<p style="text-align: center;">✓</p> May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	✓	
Full-time nursing care in your home.	✓	
		✓
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Monthly gym memberships		<p style="text-align: center;">✓</p> No-cost gym memberships are available to all members through our Senior Fit® program at designated locations. Please see the “Health and wellness education programs” section in the Medical Benefits Chart for more information.

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Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Naturopath services (uses natural or alternative treatments).	✓	
Non-routine dental care		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes		✓ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Private room in a hospital.		✓ Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered.
Routine dental care, such as cleanings, fillings or dentures.	✓	Please see Chapter. 4, Section 2 for benefit details.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.	✓	Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes).
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Please see Chapter. 4, Section 2 for benefit details.

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Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veteran Affairs (VA) facilities.		<p style="text-align: center;">✓</p> When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Supportive devices for the feet		<p style="text-align: center;">✓</p> Orthopedic or therapeutic shoes for people with diabetic foot disease.
Surgical treatment for morbid obesity		<p style="text-align: center;">✓</p> Except when it is considered medically necessary and covered under Original Medicare
Wigs and cranial prosthesis.	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

*Using the plan's coverage for
your Part D prescription drugs*

Chapter 5. Using the plan's coverage for your Part D prescription drugs**Chapter 5. Using the plan's coverage for your Part D prescription drugs**

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Chapter 5. Using the plan's coverage for your Part D prescription drugs

 Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

Chapter 5. Using the plan's coverage for your Part D prescription drugs**SECTION 1 Introduction****Section 1.1 This chapter describes your coverage for Part D drugs**

This chapter **explains rules for using your coverage for Part D drugs**. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, CDPHP Group Medicare Rx (HMO) also covers some drugs under the plan's medical benefits. Through its coverage of Medicare Part A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B, and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit. For more information, please see Section 9.4 (*What if you're in Medicare-certified hospice*). For information on hospice coverage, see the hospice section of Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy* or through the plan's mail-order service.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)

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- Your drug must be used for a medically accepted indication. A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 To have your prescription covered, use a network pharmacy

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

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

Section 2.2 Finding network pharmacies**How do you find a network pharmacy in your area?**

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (<https://www.cdphp.com>), or call Member Services (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at <https://www.cdphp.com>.

What if you need a specialized pharmacy?

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

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- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficulty accessing your Part D benefits in an LTC facility, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Section 2.3	Using the plan's mail-order services
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For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs provided through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. All drugs on Tiers 1, 2, 3, and 4 are available through the plan's mail-order service. Tier 5 drugs are available only as a 30-day supply through the plan's mail-order service.

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

To get order forms and information about filling your prescriptions by mail, visit our website (<https://www.cdphp.com>).

Usually a mail-order pharmacy order will get to you in no more than 14 days. If you have not received your mail-order prescription in 14 days and you are out of medication, contact CVS Caremark Customer Care at 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

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

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail order services with this plan in the past, or
- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by continuing to have your doctor send us your prescriptions. No special request

Chapter 5. Using the plan's coverage for your Part D prescription drugs

is needed. Or you may contact CVS Caremark Customer Care at 1-866-289-2319 to restart automatic deliveries if you previously stopped automatic deliveries.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact CVS Caremark Customer Care at 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact CVS Caremark Customer Care at 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program, we will start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you prior to shipping each refill to make sure you are in need of more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed. If you choose not to use our auto refill program, please contact your pharmacy 14 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please contact us by calling 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you. You can contact CVS Caremark Customer Care at 1-866-289-2319, 24 hours a day, seven days a week. TTY/TDD users should call 711.

Section 2.4	How can you get a long-term supply of drugs?
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The plan offers two ways to get a long-term supply (also called an “extended supply”) of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.) You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services**. All drugs on Tiers 1, 2, 3, and 4 are available through the plan's mail-order service. Tier 5 drugs are available only as a 30-day supply through the plan's mail-order service. Our plan's mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5	When can you use a pharmacy that is not in the plan's network?
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Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy that provides 24-hour service within a reasonable driving distance.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high-cost and unique drugs).

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

Chapter 5. Using the plan's coverage for your Part D prescription drugs**SECTION 3 Your drugs need to be on the plan's "Drug List"****Section 3.1 The "Drug List" tells which Part D drugs are covered**

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information; the DRUGDEX Information System; and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 3.2 There are five "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

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- Cost-Sharing Tier 1 is called “Preferred Generic.” This is our lowest tier.
- Cost-Sharing Tier 2 is called “Generic.”
- Cost-Sharing Tier 3 is called “Preferred Brand.” This tier includes brand and generic drugs.
- Cost-Sharing Tier 4 is called “Non-Preferred Drugs.” This tier includes brand and generic drugs.
- Cost-Sharing Tier 5 is called “Specialty Tier.” This is our highest tier; it includes brand and generic drugs.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (<https://www.cdphp.com>). The Drug List on the website is always the most current.
3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 4 **There are restrictions on coverage for some drugs**

Section 4.1	Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our drug list. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that neither the generic drug nor other covered drugs that treat the same condition will work for you, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

For certain drugs, we limit the amount of the drug that you can have by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered

Chapter 5. Using the plan's coverage for your Part D prescription drugs

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 4.3 Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (<https://www.cdphp.com>).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

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

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

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be. The plan puts each covered drug into one of five different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

Chapter 5. Using the plan's coverage for your Part D prescription drugs

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

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

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year**. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

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- **For those members who are new or who were in the plan last year and reside in a long-term care (LTC) facility:**

We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new, and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of a 31-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 31-day supply of medication.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away:**

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

If you experience a change in your level of care, such as a move from a hospital to a home setting, and you need a drug that is not on our formulary, or if your ability to get your drugs is limited, we will cover a one-time temporary supply for up to 30 days (or 31 days if you are a long-term-care resident) from a network pharmacy. During this period, you should use the plan's exception process if you wish to have continued coverage of the drug after the temporary supply is finished.

To ask for a temporary supply, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

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

Chapter 5. Using the plan's coverage for your Part D prescription drugs

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

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

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in Tier 5-Specialty Tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

Chapter 5. Using the plan's coverage for your Part D prescription drugs

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

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?**Information on changes to drug coverage**

When changes to the Drug List occur during the year, we post information on our website about those changes. We will update our online Drug List on a regularly scheduled basis to include any changes that have occurred after the last update. Below we point out the times that you would get direct notice if changes are made to a drug that you are then taking. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

Do changes to your drug coverage affect you right away?

Changes that can affect you this year: In the below cases, you will be affected by the coverage changes during the current year:

- **A new generic drug replaces a brand name drug on the Drug List (or we change the cost-sharing tier or add new restrictions to the brand name drug)**
 - We may immediately remove a brand name drug on our Drug List if we are replacing it with a newly approved generic version of the same drug that will appear on the same or lower cost sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the

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brand name drug on our Drug List, but immediately move it to a higher cost-sharing tier or add new restrictions.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
 - If you are taking the brand name drug at the time we make the change, we will provide you with information about the specific change(s) we made. This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
 - Once in a while, a drug may be suddenly withdrawn because it has been found to be unsafe or removed from the market for another reason. If this happens, we will immediately remove the drug from the Drug List. If you are taking that drug, we will let you know of this change right away.
 - Your prescriber will also know about this change, and can work with you to find another drug for your condition.
 - **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 instance, we might add a generic drug that is not new to the market to replace a brand name drug or change the cost-sharing tier or add new restrictions to the brand name drug.
 - After you receive notice of the change, you should be working with your prescriber to switch to a different drug that we cover.
 - Or you or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Changes to drugs on the Drug List that will not affect people currently taking the drug: For changes to the Drug List that are not described above, if you are currently taking the drug, the following types of changes will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List

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If any of these changes happen for a drug you are taking (but not because of a market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, the changes will affect you, and it is important to check the new year's Drug List for any changes to drugs.

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

Section 7.1 Types of drugs we do not cover

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section the only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms

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- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

In addition, if you are receiving “Extra Help” from Medicare to pay for your prescriptions, the “Extra Help” program will not pay for the drugs not normally covered. (Please refer to the plan’s Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

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SECTION 9 Part D drug coverage in special situations

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

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

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

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of 31-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care (LTC) pharmacy may provide the drug in smaller amounts at a time to prevent waste.) If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be

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covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

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

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

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

Section 9.4	What if you're in Medicare-certified hospice?
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Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage

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under Part D. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

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

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

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

We have a program that can help make sure our members safely use their prescription opioid medications, other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid benzodiazepine medications from a
- Requiring you to get all your prescriptions for opioid benzodiazepine medications from a

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- Limiting the amount of opioid or benzodiazepine medications we will cover for you

If we think that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. See Chapter 9 for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer; you are receiving hospice, palliative, or end-of-life care; or you live in a long-term care facility.

Section 10.3	Medication Therapy Management (MTM) and other programs to help members manage their medications
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We have programs that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time, and have high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members get the most benefit from the drugs they take. One program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through an MTM program. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take 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 of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

CHAPTER 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs**Chapter 6. What you pay for your Part D prescription drugs**

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Chapter 6. What you pay for your Part D prescription drugs**Did you know there are programs to help people pay for their drugs?**

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.*** We sent you a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider.” (Phone numbers for Member Services are printed on the back cover of this booklet.)

SECTION 1 Introduction**Section 1.1 Use this chapter together with other materials that explain your drug coverage**

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the five “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at <https://www.cdphp.com>. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

Chapter 6. What you pay for your Part D prescription drugs

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

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called “cost-sharing” and there are three ways you may be asked to pay.

- The “**deductible**” is the amount you must pay for drugs before our plan begins to pay its share.
- “**Copayment**” means that you pay a fixed amount each time you fill a prescription.
- “**Coinsurance**” means that you pay a percent of the total cost of the drug each time you fill a prescription.

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

Section 2.1 What are the drug payment stages for CDPHP Group Medicare Rx (HMO) members?

As shown in the table below, there are “drug payment stages” for your prescription drug coverage under CDPHP Group Medicare Rx (HMO). How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.

In addition to the Part D drugs covered under the Group Medicare Rx Plan, CDPHP has added expanded coverage, with additional categories of prescription drugs covered under the CDPHP Medicare Advantage Drug Plans Enhanced Formulary. Please review the enclosed copy of the Enhanced Formulary to see a list of covered drugs. Amounts you pay out of pocket for non-Part D drugs, including Enhanced Formulary drugs, do not count toward the calculation of total drug costs nor do they count toward your out-of-pocket maximum of \$6,350. For non-Part D drugs covered under the Enhanced Formulary, you will continue to pay the copayments noted above even after you have reached the Catastrophic Coverage level for Part D drugs.

Chapter 6. What you pay for your Part D prescription drugs

Enhanced Formulary drugs covered under this plan are not considered covered Part D drugs by Medicare; therefore, the following items do not apply to Enhanced Formulary drugs:

- 30-day advance notice of formulary changes.
- One-time fills for non-covered drugs for new members.
- Formulary exceptions for coverage levels (tier placement).
- Explanation of Benefits.

*Out of Network: Limited to a 30-day supply; you are required to pay the difference between what we would pay for a prescription filled at an in-network pharmacy and what the out-of-network pharmacy charges for your prescriptions.

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>Because there is no deductible for the plan, this payment stage does not apply to you.</p>	<p>You begin in this stage when you fill your first prescription of the year.</p> <p>During this stage, the plan pays its share of the cost of your drugs and you pay your share of the cost.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) reach \$4,020.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>Your employer’s prescription drug coverage includes coverage through the coverage gap at the copay level.</p> <p>(Details are in Section 5 of this chapter.)</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$6,350. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2021).</p> <p>(Details are in Section 7 of this chapter.)</p>

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

Section 3.1 We send you a monthly report called the “Part D Explanation of Benefits” (the “Part D EOB”)

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

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the “Part D EOB”) when you have had one or more prescriptions filled through the plan during the previous month.

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.

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- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a “Part D EOB”) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 There is no deductible for CDPHP Group Medicare Rx (HMO)

Section 4.1 You do not pay a deductible for your Part D drugs.

There is no deductible for CDPHP Group Medicare Rx (HMO). You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

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

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

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

The plan has five cost-sharing tiers

Every drug on the plan’s Drug List is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Cost-Sharing Tier 1 is called “Preferred Generic.” This is our lowest tier.
- Cost-Sharing Tier 2 is called “Generic.”

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- Cost-Sharing Tier 3 is called “Preferred Brand.” This tier includes brand and generic drugs.
- Cost-Sharing Tier 4 is called “Non-Preferred Drugs.” This tier includes brand and generic drugs.
- Cost-Sharing Tier 5 is called “Specialty Tier.” This is our highest tier; it includes brand and generic drugs.

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan’s network
- A pharmacy that is not in the plan’s network
- The plan’s mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan’s *Pharmacy Directory*.

Section 5.2	A table that shows your costs for a <i>one-month</i> supply of a drug
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During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

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Chapter 6. What you pay for your Part D prescription drugs

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

	Standard retail cost-sharing (in-network) (up to a 30-day supply)	Preferred retail cost-sharing (in-network) (up to a 30-day supply)	Mail-order cost-sharing (up to a 30-day supply)	Long-term care (LTC) cost-sharing (up to a 31-day supply)	Out-of-network cost-sharing (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$2 copayment	\$2 copayment	\$2 copayment	\$2 copayment	\$2 copayment
Cost-Sharing Tier 2 (Generic)	\$10 copayment	\$10 copayment	\$10 copayment	\$10 copayment	\$10 copayment
Cost-Sharing Tier 3 (Preferred Brand)	\$30 copayment	\$30 copayment	\$30 copayment	\$30 copayment	\$30 copayment
Cost-Sharing Tier 4 (Non-Preferred Drugs)	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment	\$50 copayment
Cost-Sharing Tier 5 (Specialty Tier)	\$55 copayment	\$55 copayment	\$55 copayment	\$55 copayment	\$55 copayment

Chapter 6. What you pay for your Part D prescription drugs**Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply**

Typically, the amount you pay for a prescription drug covers a full month's supply of a covered drug. However, your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.
 - Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is \$30. This means that the amount you pay per day for your drug is \$1. If you receive a 7 days' supply of the drug, your payment will be \$1 per day multiplied by 7 days, for a total payment of \$7.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill dates for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

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

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term up to a 90-day supply of a drug.

- Please note: If your covered drug costs are less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Chapter 6. What you pay for your Part D prescription drugs**Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:**

	Standard retail cost-sharing (in-network) (up to a 90-day supply)	Preferred mail-order cost-sharing (in-network) (up to a 90-day supply)	Mail-order cost-sharing (up to a 90-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	\$6 copayment	\$4 copayment	\$6 copayment
Cost-Sharing Tier 2 (Non-Preferred Generic)	\$30 copayment	\$20 copayment	\$30 copayment
Cost-Sharing Tier 3 (Preferred Brand)	\$90 copayment	\$60 copayment	\$90 copayment
Cost-Sharing Tier 4 (Non-Preferred Drugs)	\$150 copayment	\$100 copayment	\$150 copayment
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5	A long-term supply is not available for drugs in Tier 5

Section 5.5	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$4,020
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You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$4,020 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2021, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

Chapter 6. What you pay for your Part D prescription drugs

The *Part D Explanation of Benefits* (Part D EOB) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf during the year. Many people do not reach the \$4,020 limit in a year.

We will let you know if you reach this \$4,020 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, the plan provides some drug coverage

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$6,350

Once you have reached your Initial Coverage Limit totaling \$4,020, a Coverage Gap begins. In the Coverage Gap under this rider you pay the copayments listed in Sections 5.2 and 5.4 of this chapter. You continue to pay these copayments for all brand-name drugs (as defined by CMS) until your total out-of-pocket Part D drug expenditures reach \$6,350.

The Medicare Coverage Discount Program provides the manufacturer discounts on brand name drugs to Part D enrollees who have reached the Coverage Gap and are not already receiving “Extra Help.” A 70% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount. Although you pay the same copayments in the coverage gap as during the initial coverage stage, the 70% manufacturer discount still applies. Both the amount you pay, and the 70% discounted by the manufacturer, count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare’s rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage
 - The Coverage Gap Stage

Chapter 6. What you pay for your Part D prescription drugs

- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$6,350 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.

Chapter 6. What you pay for your Part D prescription drugs

- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Affairs.
- Payments for your drugs made by a third party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

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

- **We will help you.** The Part D Explanation of Benefits (Part D EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$6,350 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up-to-date.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

Section 7.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year
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You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$6,350 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the larger amount:
 - – Either – coinsurance of 5% of the cost of the drug
 - –Or – \$3.60 for a generic drug or a drug that is treated like a generic and \$8.95 for all other drugs.
 - For Tier 1 or Tier 5 drugs, you pay the lesser of 5% coinsurance or the cost share determined in Sections 5.2 and 5.4 of this chapter.
- **Our plan pays the rest** of the cost.

Chapter 6. What you pay for your Part D prescription drugs

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

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

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.
 - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs (Formulary)*.
- 2. Where you get the vaccine medication.**
- 3. Who gives you the vaccine.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember, you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

Chapter 6. What you pay for your Part D prescription drugs

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration)

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

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2	You may want to call us at Member Services before you get a vaccination
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

CHAPTER 7

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

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

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

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

SECTION 1 Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

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

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

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.3.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

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

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment
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Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

Mail your request for payment together with any bills or receipts to us at this address:

CDPHP
Attn: Medicare Claims
P.O. Box 66602
Albany, NY 12206

For prescription drugs, please send your written reimbursement request to:

CVS Caremark Part D Services, LLC
Attn: Medicare Paper Claims

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

P.O. Box 52066
Phoenix, AZ 85072-2066

For any prescriptions filled during the 2021 calendar year, you must submit your claim form for consideration no later than March 31, 2022.

You may also call our plan to request payment. For details, go to Chapter 2, Section 1, and look for the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received.*

You must submit your claim to us within 12 months of the date you received the service, item, or drug.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal
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If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs
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There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.

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

- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

Chapter 8. Your rights and responsibilities

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Chapter 8. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in Braille, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact the Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with CDPHP, 500 Patroon Creek Blvd., Albany, NY 12206-1057, <https://www.cdphp.com>, (518) 641-3950 or 1-888-248-6522. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact customer service at (518) 641-3950 or 1-888-248-6522 for additional information. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.

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

As a member of our plan, you have the right to choose a primary care provider in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied

Chapter 8. Your rights and responsibilities

coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.3	We must protect the privacy of your personal health information
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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.
- The laws that protect your privacy give you rights related to getting 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.
- In most situations, if we 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 first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

Chapter 8. Your rights and responsibilities

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.4	We must give you information about the plan, its network of providers, and your covered services
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As a member of CDPHP Group Medicare Rx (HMO), you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

If you want any of the following kinds of information, please call Member Services (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Directory of Plan Practitioners and Providers.
 - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
 - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at <https://www.cdphp.com>.
- **Information about your coverage and the rules you must follow when using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.5	We must support your right to make decisions about your care
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You have the right to know your treatment options and participate in decisions about your health care

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

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

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

Chapter 8. Your rights and responsibilities

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

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

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

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

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

Chapter 8. Your rights and responsibilities

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with New York State Department of Health, Office of Professional Medical Conduct, at (518) 402-0836 or 1-800-663-6114. They are available Monday through Friday, 9 a.m. to 5 p.m. Or, visit <https://www.nyhealth.gov/professionals/doctors/conduct/> to download a complaint form.

Section 1.6	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.7	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.8 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). We’re here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

Chapter 8. Your rights and responsibilities

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

Chapter 8. Your rights and responsibilities

- If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9

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

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

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Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

BACKGROUND

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern
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This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination,” or “coverage determination” or “at-risk determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

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

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<https://www.medicare.gov>).

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes. My problem is about benefits or coverage.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and appeals.”**

No. My problem is not about benefits or coverage.

Skip ahead to **Section 10** at the end of this chapter: **“How to make a complaint about quality of care, waiting times, customer service or other concerns.”**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.**
 - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
 - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at <https://www.cdphp.com>.) The form gives

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that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

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


Section 4.3 Which section of this chapter gives the details for your situation?

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”
- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal

-  Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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(coverage decisions, appeals, complaints)**

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

NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and CORF services.

For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

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 (coverage decisions, appeals, complaints)**

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2 .
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

**Section 5.2 Step-by-step: How to ask for a coverage decision
 (how to ask our plan to authorize or provide the medical care coverage you want)**

Legal Terms
When a coverage decision involves your medical care, it is called an “organization determination.”

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting.
 If your health requires a quick response, you should ask us to make a **“fast coverage decision.”**

Legal Terms
A “fast coverage decision” is called an “expedited determination.”

How to request coverage for the medical care you want

- 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.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request .

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- **However**, for a request for a **medical item or service we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours if your request is for medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
 - **However**, for a request for a **medical item or service we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more

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information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast coverage decision”

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on a request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard coverage decision”

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request**. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
 - For a request for a medical item or service we can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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- If we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or 72 hours if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a **“fast appeal.”**

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**
 - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available

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on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at <https://www.cdphp.com>. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it,
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms
A “fast appeal” is also called an “ expedited reconsideration. ”

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

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Deadlines for a “fast appeal”

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an . Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather 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 decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an . Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days

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- **If our answer is no to part or all of what you requested**, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.**
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.** The Independent Review Organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receives the decision from the review organization for expedited requests.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive the decision from the review organization for **expedited requests**.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

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- 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 on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?


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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

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- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

 Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1	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
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Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan’s *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A “medically accepted indication” is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **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.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

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

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*

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- Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?

If you are in this situation:	This is what you can do:
	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to Section 6.4 of this chapter.
If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for. You can make an appeal. (This means you are asking us to reconsider.)	Skip ahead to Section 6.5 of this chapter.

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the “Drug List” for short.)

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “ formulary exception. ”

- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in tier 4 (*Non-Preferred Drugs*). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

- 2. Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “ formulary exception. ”

- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a “ tiering exception. ”

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- If our drug list contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s). This would lower your share of the cost for the drug.
 - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains biological product alternatives for treating your condition.
 - If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 5 (*Specialty Tier*).
- If we approve your request for a tiering exception and there is more than one lower cost-sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision."

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) 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. See Sections 6.2 and 6.3 for more information about exception requests.
- **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.

Legal Terms

A “fast coverage decision” is called an “expedited coverage determination.”
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If your health requires it, ask us to give you a “fast coverage decision”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 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 or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast complaint,” which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a “standard coverage decision” about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor’s statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an . Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms

An appeal to the plan about a Part D drug coverage decision is called a plan “ redetermination. ”
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Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail, or on our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to*

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs).

- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section 1** (*How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs*).
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

Legal Terms

A “fast appeal” is also called an “ expedited redetermination. ”

If your health requires it, ask for a “fast appeal”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

Step 2: We consider your appeal and we give you our answer.

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

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast appeal.”
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have 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 does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your level 2 appeal within 14 calendar days after it receives your request.
- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If 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 on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also 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 has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don’t understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can “**request an immediate review.**” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
 - You or someone who is acting on your behalf sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- 3. Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and . (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
 - If you miss the deadline for contacting the Quality Improvement must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms

A “fast review” is also called an “**immediate review**” or an “**expedited review.**”

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that 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.

Legal Terms

This written explanation is called the “**Detailed Notice of Discharge.**” You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
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If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You 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 stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date. If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: We do a “fast review” of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 Alternate Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made

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when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

**Section 8.1 This section is about three services only:
Home health care, skilled nursing facility care, and Comprehensive
Outpatient Rehabilitation Facility (CORF) services**

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

Legal Terms

In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

2. You sign the written notice to show that you received it.

- You or someone who is acting on your behalf the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it’s time to stop covering certain kinds of medical care.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

How can you contact this organization?

- The written notice you received 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, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a “fast-track appeal” (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal noon of the day the
- If you miss the deadline for contacting the Quality Improvement Organizatio
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Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms
This notice of explanation is called the “ Detailed Explanation of Non-Coverage. ”

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 to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you**. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. 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 another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made 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.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 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 that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision, making an appeal, or making a complaint about your medical care and Part D prescription drugs.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Step 2: We do a “fast review” of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get 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, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms
The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1	Levels 3, 4 and 5 for Medical Service
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This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called 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** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Level 5 Appeal: A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Section 9.2

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called 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.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the Administrative Law Judge or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your 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.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.


**Chapter 9. What to do if you have a problem or complaint
 (coverage decisions, appeals, complaints)**

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

 If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can “make a complaint”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

**Chapter 9. What to do if you have a problem or complaint
 (coverage decisions, appeals, complaints)**

Complaint	Example
Information you get from us	<ul style="list-style-type: none"> • Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?
<p>Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)</p>	<p>The process of asking for a coverage decision and making appeals is explained in Sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for “making a complaint” is “filing a grievance”

Legal Terms
<ul style="list-style-type: none"> • What this section calls a “complaint” is also called a “grievance.” • Another term for “making a complaint” is “filing a grievance.” • Another way to say “using the process for complaints” is “using the process for filing a grievance.”

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call (518) 641-3950 or 1-888-248-6522. If your complaint involves a

**Chapter 9. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

behavioral health service, or alcohol or substance abuse services, please call us at 1-888-320-9584. TTY/TDD users should call 711. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- You may write to us at CDPHP, Attn: Medicare Appeals and Grievances, P.O. Box 66209, Albany, NY 12206. A designated representative of CDPHP will coordinate the review and investigation of your grievance. When the grievance pertains to clinical matters, one or more qualified personnel including, but not be limited to, licensed, certified, or registered health care professionals will review the grievance. CDPHP will provide to you, or your designee, a written decision concerning the grievance within 30 calendar days after receipt of the grievance. Please note that we may extend the time frame for rendering a decision up to 14 days if you request an extension, or if CDPHP justifies the need for additional information, and documents how the delay is in the interest of the member. CDPHP will immediately provide written notification of the delay and the reasons for the delay.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**

Legal Terms

What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - 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.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint
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You can submit a complaint about CDPHP Group Medicare Rx (HMO) directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

Chapter 10. Ending your membership in the plan

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Chapter 10. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in CDPHP Group Medicare Rx (HMO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

It is important that you contact your employer's benefits administrator with questions about disenrolling from CDPHP Group Medicare (HMO).

SECTION 2 Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 2.1 Until your membership ends, you are still a member of our plan

If you leave CDPHP Group Medicare Rx (HMO), it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

Chapter 10. Ending your membership in the plan

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 3 CDPHP Group Medicare Rx (HMO) must end your membership in the plan in certain situations

Section 3.1	When must we end your membership in the plan?
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CDPHP Group Medicare Rx (HMO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 60 days.
 - We must notify you in writing that you have 60 days to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Chapter 10. Ending your membership in the plan

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 3.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health
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CDPHP Group Medicare Rx (HMO) is not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 3.3	You have the right to make a complaint if we end your membership in our plan
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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. You can look in Chapter 9, Section 10 for information about how to make a complaint.

CHAPTER 11

Legal notices

Chapter 11. Legal notices

Chapter 11. Legal notices

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Chapter 11. Legal notices

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Services (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Capital District Physicians' Health Plan, Inc. (CDPHP) complies with applicable federal civil-rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. CDPHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

CDPHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, etc.)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters

Chapter 11. Legal notices

- Information written in other languages

If you need these services, contact the CDPHP civil rights coordinator.

CDPHP Civil Rights Coordinator, 500 Patroon Creek Blvd., Albany, NY 12206, 1-844-391-4803 (TTY/TDD: 711), fax (518) 641-3401. You can file a grievance by mail or fax, or electronically at <https://www.cdphp.com/customer-support/email-cdphp>. If you need help filing a grievance, the CDPHP civil rights coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20211, 1-800-368-1019 (TDD 1-800-537-7697).

Complaint forms are available at <https://www.hhs.gov/ocr/office/file/index.html>.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, CDPHP Group Medicare Rx (HMO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

CHAPTER 12

Definitions of important words

Chapter 12. Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of CDPHP Group Medicare Rx (HMO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and 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. There is no limit to the number of benefit periods.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$6,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Chapter 12. Definitions of important words

Complaint - The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance,” in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services 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, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan’s monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed “copayment” amount that a plan requires when a specific service or drug is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you are required to pay a copayment.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of five cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Chapter 12. Definitions of important words

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A “daily cost-sharing rate” may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month's supply in your plan is 30 days, then your “daily cost-sharing rate” is \$1 per day. This means you pay \$1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, 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.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Enhanced Primary Care Physician – CDPHP network physicians who are with a practice that is committed to providing better, more comprehensive care by expanding office hours, spending more time with patients, and focusing on a higher-quality overall experience.

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

Chapter 12. Definitions of important words

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 determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a “generic” drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about us or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide 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). Home health aides do not have a nursing license or provide therapy.

Hospice - A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug costs, including amounts you have paid and what your plan has paid on your behalf, for the year have reached \$4,020.

Chapter 12. Definitions of important words

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, 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.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an intermediate care facility for the mentally retarded (ICF/MR), and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

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.

Chapter 12. Definitions of important words

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). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare or make changes to your Part D coverage. The Open Enrollment Period is from January 1 until March 31, 2021.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Chapter 12. Definitions of important words

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. See Chapter 2 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they 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. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision 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 booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Chapter 12. Definitions of important words

Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “**Medicare Advantage (MA) Plan.**”

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive “Extra Help” from Medicare to pay your prescription drug plan costs, you will not pay a late enrollment penalty.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Physician (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider

Chapter 12. Definitions of important words

before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Physicians.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are 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. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Chapter 12. Definitions of important words

Standard Cost-sharing– Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

CDPHP Group Medicare Rx (HMO) Member Services

Method	Member Services – Contact Information
CALL	(518) 641-3950 or 1-888-248-6522 Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Our hours are 8 a.m. – 8 p.m. seven days a week from October 1 to March 31. From April 1 to September 30, our hours are 8 a.m. – 8 p.m. Monday – Friday. A voice messaging service is used after hours, weekends, and federal holidays. Calls will be returned within one business day.
FAX	(518) 641-3507
WRITE	500 Patroon Creek Blvd., Albany, NY 12206-1057 <u>Error! Hyperlink reference not valid.</u>
WEBSITE	https://www.cdphp.com

Health Insurance Information Counseling & Assistance Program (HIICAP) (New York State 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	Contact Information
CALL/TTY/WRITE	County-specific phone numbers are listed in Chapter 2 Section 3 of the <i>Evidence of Coverage</i>
WEBSITE	https://aging.ny.gov


PRA Disclosure Statement According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



A plan for life.

Capital District Physicians' Health Plan, Inc.
500 Patroon Creek Blvd., Albany, NY 12206-1057
(518) 641-3950 or 1-888-248-6522
<https://www.cdphp.com>

ATTACHMENT 35



NEW YORK
STATE OF
OPPORTUNITY

**Department of
Civil Service**

Commercial Benefits Chart
“Health Maintenance Organizations
Specifications for the New York State Health Insurance
Program”

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Office Visit	Covered as required by Federal and NYS law and/or regulation	Form #01-0003-2021, XXCI, Pg 110		Pending NYS DFS Approval	\$20 copayment	Unlimited	No	All 2021 NYSHIP Rates are Estimated	All 2021 NYSHIP Rates are Estimated
Specialty Office Visit	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No	Pending NYS DFS approval: Capital Are w/ Rx: \$848.50 w/o Rx: \$691.93 Mid-Hudson w/Rx \$1079.85 w/o Rx \$923.28 Syracuse w/ Rx \$884.13 w/o Rx \$727.56	Pending NYS DFS approval: Capital Are w/ Rx: \$1,129.83 w/o Rx \$1,729.83 Mid-Hudson w/Rx \$2,699.63 w/o Rx \$2,308.20
Chiropractic Care	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No	Utica/Watertown w/ Rx: \$958.07 w/o Rx \$801.50	Syracuse w/ Rx \$2,210.34 w/o Rx \$1,818.91 Utica/Watertown w/ Rx: \$2,395.18 w/o Rx \$2,003.75
Inpatient Hospital Care	Covered as required by Federal and NYS law and/or regulation, not subject to deductibles, copays or coinsurance			Pending NYS DFS Approval	Covered in full	Unlimited	No		
Surgery (include all settings - Physician-Inpatient, Physician-Outpatient (at a hospital, facility or surgery center), Physician's Office, Outpatient Surgery Facility)				Pending NYS DFS Approval	Outpatient hospital/ freestanding: \$75 copayment Inpatient: Covered in full Office visit: \$20 copayment	Unlimited	No		
Skilled Nursing Facilities				Pending NYS DFS Approval	Covered in full	45 days per benefit period	No		
Hospice Benefits	210 Days			Pending NYS DFS Approval	Covered in full	210 days/year, also includes 5	No		
Emergency Room	Covered as required by ACA			Pending NYS DFS Approval	\$50 copayment	Waived if admitted	No		
Urgent Care Facility				Pending NYS DFS Approval	\$25 copayment	Unlimited; non participating urgent care facility services within CDPHP service area not covered.	No		
Ambulance indicate both Non-airborne & Airborne				Pending NYS DFS Approval	\$50 copayment	Unlimited	No		

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings									
Radiology	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment (waived if performed by a preferred radiology site)	Unlimited	No		
Lab Tests	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment (waived if performed by a preferred laboratory site)	Unlimited	No		
Pathology	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment (waived if performed by a preferred laboratory site)	Unlimited	No		
EKG/EEG	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment (waived if performed by a preferred radiology site)	Unlimited	No		
Radiation/ Chemotherapy	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No		
Preventive Services									
All Members - including but not limited to: annual wellness visit/ physical, standard immunizations (recommended by ACIP), colonoscopy, screening for STDs, HIV. Alcohol/ substance abuse, tobacco use, cholesterol, diabetes and high blood pressure	Covered as required by Federal and NYS law and/or regulation, and ACA			Pending NYS DFS Approval	\$0 copay; Items or services with an "A" or "B" rating from the United States Preventive Services/Routine Colonoscopy: for members 50 and above once every 10 years Task Force; B. Immunizations pursuant to the Advisory Committee on Immunization Practices ("ACIP") recommendations; and C. Preventive care and screenings that are provided for in the comprehensive guidelines supported by the Health Resources and Services Administration ("HRSA")	Children: Covered in full first 2wks., 2mos., 4mos., 6mos., 9mos., 12mos., 15mos., 18mos., 24 mos., then ages 3-19, one per year covered in full; Adult: 19 and up one per year covered in full. Includes standard immunizations and screenings mentioned above. Routine Colonoscopy: for members 50 and above once every 10 years	No		

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Women's Health - including but not limited to: mammograms, bone density, pap tests, anemia, iron deficiency, etc. for pregnant women	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	Covered in full	RoutineMammogram ages 35 and up covered in full Nonroutine covered in full (no age limit) Bone Density: ages 60 and up pap tests covered in full no age limits	No		
Men's Health - including but not limited to: prostate cancer screening, abdominal aortic aneurysm screening	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	Covered in full	Age 50 and over who are asymptomatic and for men age 40 and over with a family history	No		
Children's Health - including but not limited to: certain newborn screenings, metabolic screenings, vision, autism, lead and TB screenings, obesity counseling	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$0 copayment-Newborn screenings, routine vision when performed during a well visit, lead, TB screenings covered in full; NYS autism mandate applies – \$20 copayment for habilitation services; Obesity counseling when performed as part of preventive visit covered in full;aged 3 to 18 years with a body mass index (BMI) > 85th percentile are eligible to receive four office visits with a primary care physician (PCP) and four visits with a registered dietitian per year for monitoring and counseling with a \$20 copayment each.	Unlimited	No		
Women's Health Care/OB GYN									
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS App	\$20 (initial copayment to determine diagnosis) \$0 copayment for subsequent visits	Unlimited	No		
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling			Pending NYS DFS Approval	Covered in full	Unlimited	No		

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Infertility Services	Covered as required by Federal and NYS law and/or regulation and the infertility mandates of 2002 and 2019			Pending NYS DFS Approval	\$20 OV copayment, \$0 inpatient copayment	Medical Infertility Diagnosis and Fertility Preservation Services are Unlimited Advanced Infertility Services limited to (3) cycles of in vitro fertilization per lifetime.	No		
Contraceptive Drugs and Devices	Covered as required by ACA and NYS law and/or regulation whichever provides the higher level of benefit			Pending NYS DFS Approval	Contraceptives are covered in full	Unlimited	No		
Rehabilitative Care, Physical, Speech & Occupational Therapy									
Inpatient Rehabilitative Care				Pending NYS DFS Approval	Covered in full	60 days per plan year combined therapies. *Inpatient Short Term Rehabilitative Services (Physical, speech and occupational therapy.)	No		
Outpatient Rehabilitative Care				Pending NYS DFS Approval	\$20 copayment services must be provided by an ABA licensed provider for the diagnosis of autism spectrum disorder.	PT= 30 visits per year OT= 30 visits per year ST=20 visits per year	No		
Mental Health/Substance Abuse									
Outpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No		
Inpatient Mental Health	Covered as required by Federal and NYS laws and/or regulation			Pending NYS DFS Approval	Covered in full	Unlimited	No		
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)			Pending NYS DFS Approval	\$20 copayment	Coverage includes ABA treatment and Assistive Communication Devices *ABA services are unlimited	No		
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS laws and/or regulation			Pending NYS DFS Approval	Covered in full (inpatient detoxification services)	Unlimited	No		
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No		
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS laws and/or regulation.			Pending NYS DFS Approval	Covered in full	Unlimited	No		

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
<p>Prescription Drugs: Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.</p>									
Prescription Drugs				Pending NYS DFS Approval	Tier 1: \$5 copay, Tier 2: \$30 copay, Tier 3: \$50 copay Mail order: 2 copays for 31-60 day supply, Mail order: 2 copays for 90-day supply.	Unlimited	Yes, decrease mail order from 2.5 for a 90 day supply		
Other									
Diabetic Supplies	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment	Unlimited	No		
Oral Agents and Insulin	Covered as required by Federal and NYS law and/or regulation			Pending NYS DFS Approval	\$20 copayment per 30 day supply	Total member out of pocket cost capped at \$100 per 30 day supply	Yes, previous benefit was not capped		
Diabetic Shoes				Pending NYS DFS Approval	\$20 copayment	Unlimited	No		
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use & primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs & maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary.			Pending NYS DFS Approval	20% coinsurance	Unlimited	No		
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses & Ostomy Supplies. Replacements, repairs and maintenance, not provided for under manufacturer's warranty or purchase agreement must be covered when functionally necessary			Pending NYS DFS Approval	20% coinsurance	Unlimited	No		

Offeror Name:

HMO BENEFITS FOR 2021 -- Commercial Plan

Covered Service	HMO Benefits	Source Document: Enter Article, Section, etc. and Page Number of Contract/ Certificate of Coverage (COC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021	
		Contract/ COC	Rider Number					Individual	Family
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.			Pending NYS DFS Approval	20% coinsurance	Unlimited	No		
Cardiac Rehabilitation				Pending NYS DFS Approval	\$0 copayment *\$0 copayment for walk-in visits for congestive heart failure at select providers.	Unlimited	Yes, Decrease copayment by \$20		
Pulmonary Rehabilitation				Pending NYS DFS Approval	\$0 copayment	Unlimited	Yes, Decrease copayment by \$20		
Diabetic Prevention Program				Pending NYS DFS	Cost share would	Unlimited	No		
Telemedicine				Pending NYS DFS	\$20 copayment	Unlimited	No		
Exercise Facility reimbursement				Pending NYS DFS Approval	Subscriber can earn up to \$400 reimbursement for going to the gym or participating in digital fitness classes, dependent can earn up to \$200 – a total of \$600 per family	Limited to \$400 Individual / \$600 family	Yes, Adding Dependent eligibility (other than spouse) and digital classes to fitness reimbursement.		
Out of Pocket Maximum				Pending NYS DFS Approval	\$8,550 Individual / \$17,100 Family		Yes, increased from \$6,850 individual / \$13,700 family		

ATTACHMENT 36



Offeror name:

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Office Visit		Chapter 4, Page 77		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	
Specialty Office Visit		Chapter 4, Page 77		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	Part C - Medical (MA Only) \$205.90
Chiropractic Care		Chapter 4, Page 55		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	Part C - Medical (MAPD) \$205.90 Part D- \$2/\$10/\$30/\$50/\$55 \$191.40 Total for MAPD: \$397.30
Inpatient Hospital Care	Not subject to deductibles, copays or coinsurance	Chapter 4, Page 65		Draft - Pending language from CMS	Covered in Full	Unlimited	No	
Surgery (include all settings - Physician-Inpatient , Physician-Outpatient (at a hospital, facility or surgery center), Physician’s Office, Outpatient Surgery Facility		Chapter 4, Page 65, Outpatient Page 76		Draft - Pending language from CMS	Inpatient Covered in full Outpatient \$75 copayment	Unlimited	No	(Rates are estimated pending CMS approval for 2021 Medicare bid filing)
Skilled Nursing Facilities		Chapter 4, page 82		Draft - Pending language from CMS	Covered in Full	Limited to 100 days per benefit period	No	
Hospice Benefits		Chapter 4, Page 62		Draft - Pending language from CMS	N / A	Hospice is covered under Original Medicare parts A & B	No	
Emergency Room		Chapter 4, page 59		Draft - Pending language from CMS	\$75 copayment, waived if admitted within 24 hours	Unlimited	No	
Urgent Care Facility		Chapter 4, page 84		Draft - Pending language from CMS	\$30 copayment	Unlimited	No	
Ambulance indicate both Non-airborne & Airborne		Chapter 4, Page 52		Draft - Pending language from CMS	\$75 copayment	Unlimited	No	

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Diagnostic/Therapeutic Services: Cite both Hospital and Medical/Surgical Settings								
Radiology		Chapter 4, Page 72		Draft - Pending language from CMS	X-ray/Ultrasound \$20 copayment; Advanced Radiology \$40	Unlimited	no	
Lab Tests		Chapter 4, Page 72		Draft - Pending language from CMS	\$20 copayment, Waived if provider is preferred	Unlimited	No	
Pathology		Chapter 4, page 72		Draft - Pending language from CMS	\$20 copayment, Waived if provider is preferred	Unlimited	No	
EKG/EEG		Chapter 4, Page 77		Draft - Pending language from CMS	\$20 copayment, waived when performed during a routine annual physical	Unlimited	No	
Radiation/ Chemotherapy		Chapter 4, Radiation Page 72; Part B drugs including chemotherapy Page 70		Draft - Pending language from CMS	Radiation \$20 copayment. Part B drugs including chemotherapy: Office administered \$20 per date of service; Retail pharmacy \$20 per prescription	Unlimited	No	
Women's Health Care/OB GYN								
Pap Tests		Chapter 4, Page 54		Draft - Pending language from CMS	Covered in Full	For all women: Pap tests and pelvic exams are covered once every 24 months. If	No	
Mammograms		Chapter 4, Page 53		Draft - Pending language from CMS	Covered in Full	One screening mammogram every 12 months for women 40+	No	
Bone Mineral Density Measurements & Tests		Chapter 4, Page 53		Draft - Pending language from CMS	Covered in Full	Covered once every 24 months or more frequently if medically necessary	No	
Pre- and Post Natal Visits	Covered as required by Federal and NYS law and/or regulation	Specialist visit – Chapter 4, Page77		Draft - Pending language from CMS	Specialty Office visit, \$20 copayment	Unlimited	No	
Family Planning	Routine examinations; laboratory tests; birth control counseling; pregnancy testing; genetic counseling	Specialist visit – Chapter 4, Page77		Draft - Pending language from CMS	Specialty Office visit, \$20 copayment	Medically necessary	No	

HMO BENEFITS FOR 2021 - Medicare Advantage Plan

Covered Service	HMO Medicare Advantage Benefits (coverage as required by CMS and/or NYS laws and/or regulations)	Source Document: Enter Article, Section, etc. and Page Number of Evidence of Coverage (EOC), Rider Number		NYS DFS Status: Approved (include date) or Filed/ Pending	Member Cost: Enter copay/ coinsurance amount, e.g., \$25/visit, 20% coinsurance	Benefit Limitations: e.g., 20 visits/ calendar year, 60 consecutive days Indicate "unlimited" if no limitations	Change from 2020 Enter: Yes/No and change, e.g., \$5 copay increase, new benefit	Projected Monthly Premium for 2021
		EOC	Rider					Individual
Infertility Services	Covered as required by Federal and NYS law and/or regulation	Specialist visit – Chapter 4, Page77		Draft - Pending language from CMS	Specialty Office visit \$20 copayment diagnostic testing and/or other copayments may apply	Medically necessary	No	
Contraceptive Drugs and Devices		Chapter 6	Rider 559	Draft - Pending language from CMS	Contraceptives are covered under the enhanced formulary	Unlimited	No	

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		EOC	Rider					Individual
Rehabilitative Care, Physical, Speech & Occupational Therapy								
Inpatient Rehabilitative Care		Chapter 4, Page 65		Draft - Pending language from CMS	Covered in Full	Unlimited	No	
Outpatient Rehabilitative Care		Chapter 4, Page 76		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	
Mental Health/Substance Abuse								
Outpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 75		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	
Inpatient Mental Health	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 67		Draft - Pending language from CMS	Covered in full	190 day lifetime limit in a psychiatric hospital	No	
Coverage for Autism Spectrum Disorder	In compliance with NYS Autism legislation including Habilitative Services, Applied Behavior Analysis (ABA)	Specialist visit - Chapter 4, page 77		Draft - Pending language from CMS	Specialty office visit, \$20 copayment	Medicare Advantage plans are not subject to the NYS Autism legislation as these products are Federal products filed with CMS (Center for Medicare and Medicaid Services).	No	
Alcohol and Substance Abuse Detoxification	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 76		Draft - Pending language from CMS	\$20 Office visit copayment Inpatient covered in full.	Unlimited	No	
Outpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 76		Draft - Pending language from CMS	\$20 copayment	Unlimited	No	
Inpatient Alcoholism and Substance Abuse Rehabilitation	Covered as required by Federal and NYS law and/or regulation	Chapter 4, Page 65		Draft - Pending language from CMS	Covered in Full	Unlimited	No	
<p>Prescription Drugs: Medically necessary federal legend and state restricted drugs, compounded medications and injectable insulin. Coverage must include contraceptive drugs and devices, fertility drugs and enteral formulas. (The copayment for injectable drugs, including fertility drugs, must be the same as the copayment for other covered drugs except drugs limited to 30 days supply at dispensing.) No annual or lifetime maximum permitted.</p>								
Prescription Drugs		Chapter 4, page 121	559	Draft - Pending language from CMS	\$2/\$10/\$30/\$50/\$55, Mail order tiers 1-4 are 2 copayments	Unlimited - Additional information found in Chapter 6	No	

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<i>Other</i>								
Diabetic Supplies		Chapter 4, page 58		Draft - Pending language from CMS	\$10 or 20% coinsurance, whichever is less for Diabetic supplies	Unlimited	No	
Oral Agents and Insulin		Chapter 6, page 151	559	Draft - Pending language from CMS	Covered under Part D, See formulary for copayment	Unlimited	No	
Diabetic Shoes		Chapter 4, page 58		Draft - Pending language from CMS	20% coinsurance	One pair per calendar year	No	
Durable Medical Equipment (DME)	Medically necessary DME which can with- stand repeated use and primarily used to serve a medical purpose must be covered. Examples include but not limited to: wheelchairs, walkers, respiratory equip, oxygen supplies, replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Chapter 4, Page 59		Draft - Pending language from CMS	20% coinsurance	Prior authorization may apply	No	
Prosthetic Devices	Medically necessary prosthetic devices that aid body functioning or replace a limb or body part in order to correct a defect of body form or function must be covered. Examples of prosthetic devices include but are not limited to: artificial limbs, pacemakers, heart valve replacements, artificial joints, external breast prostheses and Ostomy Supplies. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Chapter 4, Page 59		Draft - Pending language from CMS	20% coinsurance	Prior authorization may apply. Not covered: Wigs and cranial prosthesis	No	

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		EOC	Rider					Individual	
Orthotic Devices	Medically Necessary custom-made orthotic devices used to support, align, prevent or correct deformities or to improve the function of the foot must be covered. Orthopedic shoes and other supportive devices for treatment of weak, strained, flat, unstable or unbalanced feet should not be included for coverage. Replacements, repairs and maintenance, not provided for under a manufacturer's warranty or purchase agreement, must be covered when functionally necessary.	Chapter 4, Page 59		Draft - Pending language from CMS	20% coinsurance	Prior authorization may apply Not Covered: * Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.* Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.	No		
Cardiac Rehabilitation		Chapter 4, Page 54		Draft - Pending language from CMS	\$0 copayment *\$0 copayment for walk-in visits for congestive heart failure at select providers.	Maximum of 72 intensive cardiac rehabilitation visits	Yes, Decrease copayment by \$20		
Pulmonary Rehabilitation		Chapter 4, Page 80		Draft - Pending language from CMS	\$0 copayment	Unlimited	Yes, Decrease copayment by \$20		
Telemedicine		Chapter 4, Page 77		Draft - Pending language from CMS	\$20 copayment	Unlimited	No		

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Acupuncture	New Acupuncture Manadate - Pending language from CMS	Pending Language from CMS for Mandate		Draft - Pending language from CMS	50% coinsurance	Medicare-mandated coverage for acupuncture for chronic low back pain only . Up to 12 visits in 90 days are covered. 10 acupuncture visits for any diagnosis in addition to the Medicare-mandated benefit.	No	
Allowances		Chapter 4, Page 85; Page 56		Draft - Pending language from CMS	Annually: \$100 eyewear allowance, \$150		No	
Hearing Aids through Hearing Care Solutions		Chapter 4, Page 61		Draft - Pending language from CMS	Choose between two technology levels of hearing aid with Hearing Care Solutions and get two hearing aids for a copayment - Premier \$199 Premium \$499	One covered hearing aid per ear, per benefit year unless hearing needs change.	Yes, Changed from \$200 allowance to copayment design	
Fitness		Chapter 4, Page 60		Draft - Pending language from CMS	Senior Fit including Silver Sneakers Locations	Unlimited	No	
LifePoints through CafeWell		Chapter 4, Page 60		Draft - Pending language from CMS	\$125 LifePoints	Limited to \$125	No	