VNS Health

VNS Health Total (HMO D-SNP)

A Medicare Advantage and Medicaid Advantage Plus Program

2024

MEMBER HANDBOOK: YOUR EVIDENCE OF COVERAGE

January 1 – December 31, 2024

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of VNS Health Total (HMO D-SNP)

This document gives you the details about your Medicare and Medicaid health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact your Care Team at 1-866-783-1444. (TTY users should call 711). Hours are 7 days a week, 8 am – 8 pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.). This call is free.

This plan, VNS Health Total, is offered by VNS Health Medicare (When this Evidence of Coverage says "we," "us," or "our," it means VNS Health Health Plans. When it says "plan" or "our plan," it means VNS Health Total.)

This document is available for free in Spanish and Chinese. You can also get this document for free in other formats, such as large print, braille, or audio.

Benefits, deductibles, and/or copayments/coinsurance may change on January 1, 2025.

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

VNS Health Medicare is a Medicare Advantage organization with Medicare and Medicaid contracts, offering HMO D-SNP and HMO plans. Enrollment in VNS Health Medicare depends on contract renewal.

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

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

OMB Approval 0938-1051 (Expires: February 29, 2024)

2024 Evidence of Coverage

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CHAPTER 1:
Getting started as a member

OMB Approval 0938-1051 (Expires: February 29, 2024)

SECTION 1 Introduction

Section 1.1 You are enrolled in VNS Health Total, which is a specialized Medicare Advantage Plan (Special Needs Plan)

You are covered by both Medicare and Medicaid:

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

You have chosen to get your Medicare and Medicaid health care and your prescription drug coverage through our plan, VNS Health Total. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

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

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

VNS Health Total is run by a not-for-profit organization. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The

plan also has a contract with the New York State Medicaid program to coordinate your Medicaid benefits. We are pleased to be providing your Medicare and Medicaid health care coverage, including your prescription drug coverage long-term care and home and community-based services.

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

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

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

The words coverage and covered services refer to the medical care, long-term care and/or home and community-based services and services and the prescription drugs available to you as a member of VNS Health Total.

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

If you are confused, concerned or just have a question, please contact your Care Team.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how *VNS Health Total* 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 VNS Health Total between January 1, 2024 and December 31, 2024.

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 VNS Health Total after December 31, 2024. We can also choose to stop offering the plan in your service area, or to offer it in a different service area, after December 31, 2024.

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

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

Section 2.1 Your eligibility requirements

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

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

Special eligibility requirements for our plan

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

VNS Health Total is a plan for people who have both Medicare and Medicaid. You are eligible to join VNS Health Total if you have Medicare, full Medicaid and:

- Are age 18 and older
- Reside in the plan's service area: Albany, Bronx, Kings, Nassau, New York, Queens, Rensselaer, Richmond, Schenectady, Suffolk, and Westchester Counties of New York State.

- Have a chronic illness or disability that makes you eligible for nursing home level of care at the time of enrollment.
- Are able to stay safely at home at the time you join the plan
- Must be eligible for nursing home level of care (as of the time of enrollment)
- Require care management and are expected to need one or more of the following services for more than 120 continuous days from the date that you join our plan:
    - Nursing services in the home
    - Therapies in the home
    - Home health aide services
    - Personal care services in the home
    - Adult day health care
    - Private Duty Nursing
    - Consumer Directed Personal Assistance Services
- Additional conditions apply. For more information about enrollment in this plan see Chapter 13.

Please note that there are certain Medicaid programs that would exclude eligibility.

An Applicant who is a hospital inpatient or is an inpatient or resident of a facility licensed by the State Office of Mental Health (OMH), the Office of Alcoholism and Substance Abuse Services (OASAS) or the State Office For People With Developmental Disability (OPWDD) or is enrolled in another managed care plan capitated by Medicaid, a Home- and Community-Based Services waiver program or OPWDD Day Treatment Program or is receiving services from a hospice may be enrolled with the Contractor upon discharge or termination from the inpatient hospital, facility licensed by the OMH, OASAS or OPWDD, other managed care plan, hospice, Home- and Community-Based Services waiver program or OPWDD Day Treatment Program.

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

Section 2.2 What is Medicaid?

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

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

- **Qualified Medicare Beneficiary Plus (QMB+):** QMB+ beneficiaries receive full Medicaid coverage, and Medicaid pays their Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). QMB+ beneficiaries automatically qualify for the Medicare Part D "Extra Help" program.
- **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 Plus (SLMB+):** SLMB+ beneficiaries receive full Medicaid coverage, and Medicaid pays their Part B premiums. SLMB+ beneficiaries automatically qualify for the Medicare Part D "Extra Help" program**.**
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

Section 2.3 Here is the plan service area for VNS Health Total

VNS Health Total 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, Bronx, Kings, Nassau, New York, Queens, Rensselaer, Richmond, Schenectady, Suffolk, and Westchester Counties.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

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

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

Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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

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

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

Section 3.2 The Provider and Pharmacy Directory

The *Provider and Pharmacy Directory* lists our current network providers and durable medical equipment suppliers.

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

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

The most recent list of providers is available on our website at vnshealthplans.org/providers.

If you don't have your copy of the *Provider and Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from your Care Team. Requests for hardcopy will be mailed to you within three business days.

SECTION 4 Your monthly costs for VNS Health Total

Your costs may include the following:

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

In some situations, your plan premium could be less.

SECTION 4.1 Plan premium

You do not pay a separate monthly plan premium for VNS Health Total. 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.)

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B.

For more VNS Health Total members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and for your Part B premium.

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

Section 4.3 Part D Late Enrollment Penalty

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

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in VNS Health Total, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

- You receive "Extra Help" from Medicare to pay for your prescription drugs.
- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or 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.

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

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is $64.28.
- 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 $64.28, which equals $9. This rounds to $73.30. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

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

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

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

Section 4.5 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount, also known as IRMAA. The extra charge is figured out using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans.

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

If you disagree about paying an extra amount, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

SECTION 5 More information about your monthly premium

Section 5.1 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 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, you may be able to stop paying a late enrollment penalty, if owed. Or need to start paying a late enrollment penalty. (This could happen if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year: If you currently pay the Part D late enrollment penalty and become eligible for "Extra Help" during the year, you would be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)

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

If any of this information changes, please let us know by calling your Care Team.

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

SECTION 7 How other insurance works with our plan

Other insurance

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

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

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the primary payer and pays up to the limits of its coverage. The one that pays second, called the secondary payer, only pays if there are costs left uncovered by the primary coverage. The secondary

payer may not pay all of the uncovered costs. If you have other insurance, tell your doctor, hospital, and pharmacy.

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

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

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

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

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

CHAPTER 2:
Important phone numbers and resources

SECTION 1 VNS Health Total contacts
(how to contact us, including how to reach your Care Team)

How to contact your Care Team

For assistance with claims, billing, or member card questions, please call or write to the VNS Health Total Care Team. We will be happy to help you./

Method	VNS Health Total Care Team – Contact Information
CALL	1-866-783-1444 Calls to this number are free. Hours are 7 days a week, 8 am – 8 pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.). Our Care Team 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. 7 days a week from 8 am – 8 pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.).
WRITE	VNS Health Health Plans - Care Team 220 East 42nd Street, New York, NY 10017
WEBSITE	vnshealthplans.org
ONLINE ACCOUNT	vnshealthplans.org/account A safe and easy way to send us a message anytime and get information about your health plan. Available to members on the first day of enrollment

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

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

Method	Coverage Decisions and Appeals for Medical Care or Part D prescription drugs – Contact Information
CALL	1-866-783-1444 Calls to this number are free. 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.)
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. 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.)
WRITE	VNS Health Health Plans - Medical Management 220 East 42nd Street, New York, NY 10017
WEBSITE	vnshealthplans.org

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

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

Method	Complaints about Medical Care – Contact Information
CALL	1-866-783-1444 Calls to this number are free. 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.)
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. 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.)
FAX	1-866-791-2213
WRITE	VNS Health Health Plans - Grievance & Appeals Grievance and Appeals PO Box 445 Elmsford, NY 10523
MEDICARE WEBSITE	You can submit a complaint about VNS Health Total directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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	1-866-783-1444 Calls to this number are free. 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.)
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.
WRITE	Send Part C payment requests to: *VNS Health* Health Plans - Claims PO Box 4498 Scranton, PA 18505 Send Part D (prescription drug) payment requests including the DMR form (Direct Member Reimbursement) and the detailed receipt to: MedImpact Healthcare Systems, Inc. PO Box 509108 San Diego, CA 92150-9108 Fax: 858-549-1569 Email: Claims@Medimpact.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.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.
WEBSITE (continued)	You can also use the website to tell Medicare about any complaints you have about VNS Health Total: • **Tell Medicare about your complaint:** You can submit a complaint about VNS Health Total directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	***Health Information, Counseling and Assistance Program (New York State SHIP)* – Contact Information**
CALL	1-800-701-0501
TTY	Please call the New York Relay Service at 711 and an operator will connect you. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Department for the Aging 2 Lafayette Street, 16th Floor New York, NY 10007-1392
WEBSITE	**https://aging.ny.gov/health-insurance-information-counseling-and-assistance**

SECTION 4 Quality Improvement Organization

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 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 State's Quality Improvement Organization) – Contact Information**
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	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
WEBSITE	**www.livantaqio.com**

SECTION 5 Social Security

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

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

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

Method	Social Security – Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8 am to 7 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 8 am to 7 pm, Monday through Friday.
WEBSITE	www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources.

In addition, there is a "Medicare Savings Program" offered through Medicaid that helps people with Medicare who have limited incomes and resources, pay their Medicare premium costs.

If you have questions about the assistance you get from Medicaid, contact the New York Medicaid.

Method	New York Medicaid – Contact Information
CALL	1-800-541-2831
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New York Medicaid Office of the Commissioner Empire State Plaza Corning Tower Albany, NY 12237
WEBSITE	**www.health.ny.gov**

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

Method	New York State Office for the Aging (Ombudsman Program) – Contact Information
CALL	1-800-342-9871
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	New York State Office for the Aging 2 Empire State Plaza Albany, NY 12223
WEBSITE	**www.aging.ny.gov**.

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

The Medicare.gov website (https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

Medicare's "Extra Help" Program

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything further to get this "Extra Help."

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048 (applications), 24 hours a day, 7 days a week;

- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office (applications) (See Section 6 of this chapter for contact information).

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

- If you need help getting evidence of your proper copayment level, please call us at 1-866-783-1444 (TTY users call 711), and let the representative know you need help getting this information. In order to get this information, we may have to contact Medicare on your behalf. Representatives are available 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.).
- 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 your Care Team if you have questions. Most of our members qualify for and are already getting Extra Help from Medicare to pay for their prescription drug plan costs.

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

Many states and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), 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 on the ADAP formulary qualify for prescription cost-sharing assistance through the New York State HIV Uninsured Care Program (ADAP). **Note:** To be eligible for the ADAP operating in your State, individuals must meet certain criteria, including proof of State residence and HIV status, low income as defined by the State, and uninsured/under-insured status. If you change plans please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 1-800-542-2437.

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 the Elderly Pharmacy Insurance Coverage (EPIC).

Method	Elderly Pharmacy Insurance Coverage (EPIC) – (New York State's 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	EPIC PO Box 15018 Albany, NY 11212-5018
WEBSITE	**www.health.ny.gov/health_care/epic/index.htm**

SECTION 8 How to contact the Railroad Retirement Board

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0," you may speak with an RRB representative from 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 *not* free.
WEBSITE	rrb.gov/

CHAPTER 3:
Using the plan for your medical and other covered services

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

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

For the details on what medical care and other services are covered by our plan, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered*).

Section 1.1 What are "network providers" and "covered services"?

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment 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 nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies equipment, and Prescription Drugs that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

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

As a Medicare and Medicaid health plan, VNS Health Total must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare (See Section 2 in Chapter 4).

VNS Health Total will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, our plan must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a referral. For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
    - If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. *Authorization should be obtained from the plan prior to seeking care.* In this situation, we will cover these services at no cost to you. For information about

getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.

- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

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

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

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

- What is a PCP?

  Your PCP is a licensed health care professional who meets state requirements and is trained to give you basic medical care. You will get routine or basic care from your PCP. Your PCP will also coordinate many of the covered services you get as a member of our plan. (Please see Chapter 12 for a definition of Primary Care Physician.)

- What types of providers may act as a PCP?

  A PCP is a health care professional, either a physician or Nurse Practitioner that you choose to coordinate your health care.

- What is the role of a PCP in the VNS Health Total plan?

  Your PCP will provide most of your care and help you arrange or coordinate many of the covered services that you get as a member in VNS Health Total. This may include:

- X-rays
- Laboratory tests
- Therapies
- Care from doctors who are specialists
- Hospital admissions, and
- Follow-up care

- What is the role of the PCP in coordinating covered services?

  As a member of VNS Health Total, your PCP will coordinate many of the covered services you get as a plan member. "Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going and making sure your services are meeting your specific health needs.

- What is the role of the PCP in making decisions about or obtaining prior authorization (PA), if applicable?

  The participating PCP who will be providing the service to the member shall make requests for services requiring Prior Authorization. Requests can be made by contacting the *VNS Health* Medical Management Department at the telephone number listed in Chapter 2 of this document.

How do you choose your PCP?

At the time of your enrollment in VNS Health Total you must select a PCP. The VNS Health Total *Provider and Pharmacy Directory* includes a list of the PCPs that are included in our plan's network. The information regarding your PCP choice is included on your enrollment application and the ID card you will receive once you become a member of VNS Health Total.

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. The selection of a PCP does not limit you to a specific group of specialists or hospitals. You can use any specialist or hospital that participates in our network for services.

If you need to change your PCP, call your Care Team and we will check to make sure that the doctor is accepting new patients. Your Care Team will change your

membership record to show the name of your new PCP. Changes to your PCP will take effect on the first day of the month following the date of the request.

Your Care Team will also send you a new membership ID card with the name of your new PCP.

VNS Health Total will also let you know when your PCP leaves the network and will help you choose another PCP so that you can keep getting covered services. If you are in the course of treatment for a specific illness or injury, please speak to your Care Team about transitional care. In some instances, you may be able to continue to receive services from the physician who is leaving the VNS Health Total network until you complete your current course of treatment.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots, COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services are covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.
- 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 your Care Team before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

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

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

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

Care Managers will help members access a Palliative Care Program or a Medicare-certified hospice program. *(Please see Chapter 12 for a definitions of Palliative Care and Hospice)*

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

- As a member of *VNS Total Health*, you do not need a referral from your PCP for network specialists or hospital. Your PCP may provide you with assistance if you need help selecting a specialist or hospital. In some instances, your physician may request that you receive additional diagnostic tests or procedures. In these instances, your physician will need to obtain prior authorization from VNS Health Total.
- The selection of a PCP does not limit you to a specific group of specialists or hospitals. You can use any specialist or hospital that participates in our network for services. Please see your *Provider and Pharmacy Directory* for a list of participating specialists and hospitals.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.

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

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

You may obtain services from out-of-network providers in the following situations:

- You are out of the service area and need dialysis
- You are in need of a special service that is not available from one of the in-network providers

- You have an emergency or are in need of urgent care

Except in an emergency, you must obtain authorization from VNS Health Total. Contact your Care Team for more information or to arrange for services.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network
- **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 your Care Team at 1-866-783-1444. TTY users call 711. Our hours are 7 days a week, 8 am – 8pm (Oct. – March), and weekdays, 8 am – 8 pm (April – Sept.). This information is also located on the back of your ID card.

What is covered if you have a medical emergency?

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

You are also covered for emergency medical care and urgently needed services when you travel outside the United States. Please see Chapter 4 for more information.

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

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

What if it wasn't a medical emergency?

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

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

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

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

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

If you need medical care that Medicare requires our plan to cover and the providers in our network cannot cover this care, you can get this care from an out-of-network provider. Authorization should be obtained from the plan prior to seeking care. In this situation, we will cover these services as if you got the care from a network provider at no cost to you.

If you require urgently needed care, please call your Primary Care Physician (PCP). If your PCP is not available, please call the plan for further instructions.

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 care services outside the United States and its territories under the following circumstances: 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. Please see the *Medical Benefits Table* in Chapter 4 for more information.

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: vnshealthplans.org for information on how to obtain needed care during a disaster.

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

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

Section 4.1 You can ask us to pay for covered services

If you have paid for your covered services or if you have received a bill for covered medical services, go to Chapter 7 (*Asking us to pay a bill you have received for covered medical services or drugs*) for information about what to do.

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

VNS Health Total covers all medically necessary services as listed in the *Medical Benefits Chart* in Chapter 4 of this document. If you receive services not covered by our plan or services obtained out-of-network and were not authorized, you are responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. Once a benefit limit has been reached, additional costs will not count toward your out-of-pocket maximum.

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

Section 5.1 What is a clinical research study?

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

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

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

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

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we

encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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

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

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

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

After Medicare has paid its share of the cost for these services, our plan will pay the rest. Like for all covered services, you will pay nothing for the covered services you get in the clinical research.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication "Medicare and Clinical Research Studies." (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.)

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

Section 6.2 Receiving care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:

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

Medicare Inpatient Hospital coverage limits do not apply.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of VNS Health Total, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call your Care Team for more information.

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

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

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage VNS Health Total will cover:

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

If you leave VNS Health Total or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:
Medical Benefits Chart
(what is covered)

SECTION 1 Understanding covered services

This chapter provides a *Medical Benefits Chart* that lists your covered services as a member of VNS Health Total. 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 You pay nothing for your covered services

Because you get assistance from Medicaid, you pay nothing for your covered services as long as you follow the plan's rules for getting your care. (See Chapter 3 for more information about the plan's rules for getting your care.)

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

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share.
- **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.)

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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

Because you are enrolled in a Medicare Advantage Plan, there is a limit on the amount you have to pay out-of-pocket each year for medical services that are covered. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. For calendar year 2024 this amount is $0.

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 $0, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan also limits your out-of-pocket costs for certain types of services

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

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered for you

Section 2.1 Your medical benefits as a member of the plan

The *Medical Benefits Chart* on the following pages lists the services VNS Health Total covers. The services listed in the *Medical Benefits Chart* are covered only when the following coverage requirements are met:

- Your Medicare and Medicaid covered services must be provided according to the coverage guidelines established by Medicare and Medicaid.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered unless it is emergent or urgent care or unless your plan or a network provider has given you a referral. This means that you will have to pay the provider in full for the services furnished.
- You have a primary care provider (a PCP) who is providing and overseeing your care.

- 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. In addition, the following services not listed in the *Medical Benefits Chart* require prior authorization:
    - Elective and non-participating hospital admissions, including mental health admissions
    - All skilled nursing facility admissions
    - All procedures considered experimental/investigational that are required by Medicare to be covered services
    - All transplants and transplant evaluations
    - Reconstructive procedures that may be considered cosmetic
    - All referrals to non-participating providers
    - The following surgeries:
        - Bariatric surgery
        - Breast cancer surgery
        - Hysterectomy
    - Surgery which may be considered cosmetic
    - Experimental/Investigational procedures
    - Clinical trials
    - Home health and visiting nurse services
    - Outpatient habilitative and rehabilitative services
    - Select radiology services including MRIs, MRAs, and PET scans
    - Select durable medical equipment as well as prosthetics and orthotics
    - Select Home Infusion Procedures/Services
    - Select Medicare Part B drugs
    - Ambulance transportation in non-emergency situations
    - Out-of-network services (except for emergency care)

Other important things to know about our coverage:

- You are covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services. Medicaid also covers services Medicare does not cover, like long-term care, home and community-based services, transportation and home health aide service.

- Like all Medicare health plans, we cover everything that Original Medicare covers. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2024* handbook. View it online at 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.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.
- Medicaid Advantage Plus is an integrated plan which allows dually eligible to enroll in the same health plan for most of your Medicare and Medicaid benefits. Medicaid Advantage Plus enrollees are entitled to all Medicaid services they would normally get under the State Medicaid Plan with no cost sharing. Therefore, any Medicaid services not included in the combined Medicare and Medicaid Advantage Plus benefit package offered by the health plan, continue to be available to the enrollee when provided by any Medicaid enrolled provider on a Medicaid fee-for-service basis. The below *Medical Benefits Chart* describes what is covered under the plan.
- If you are within our plan's one-month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we will not continue to cover Medicaid benefits that are included under the applicable Medicaid State Plan, nor will we pay the Medicare premiums or cost sharing for which the state would otherwise be liable had you not lost your Medicaid eligibility. The amount you pay for Medicare-covered services may increase during this period.

You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for Enrollees with Certain Chronic Conditions

- If you are diagnosed with any of the following chronic condition(s) identified below and meet certain medical criteria, you may be eligible for targeted supplemental benefits and or reduced cost sharing"
    - Examples include, but are not limited to, diagnosis of conditions such as heart failure, COPD, end-stage renal disease, dementia, cancer, stroke, or other conditions.

- If you are eligible for the Palliative Care program as outlined above, it is available to you at no additional cost. This program is designed to provide an additional layer of support alongside your current medical treatment.

(See definition of "Palliative Care" in the benefit chart below.)

If you are eligible and enroll in the Palliative Care program, a member of your Care Team will call you at least monthly. Together with your Care Manager, you will plan the frequency of calls to provide you support and make sure your services are meeting your specific health needs and discuss other resources you may need. In addition, you will receive the following support through care management services:

- Comprehensive care assessment
- Care planning and goals of care discussions
- Access to social services and community resources
- Coordination with your Primary Care Physician

Important Benefit Information for all Enrollees Participating in Wellness and Health Care Planning (WHP) Services

- Because VNS Health Total participates in the VNS Health Palliative Care Program, you will be eligible for the following WHP services, including advance care planning (ACP) services:
  - Care Managers will offer Advance Care Planning over the phone as needed. You may also complete advance directives during your periodical home assessment visit conducted by a nurse practitioner (NP). This ACP is voluntary.
  - Advance Care Planning is an ongoing process to engage you and your family in conversation about your goals, values, and beliefs. Care Managers will offer Advance Care Planning over the phone as needed. You may also complete advance directives during your periodic home assessment visit conducted by an NP.

Medicare approved VNS Health Medicare to provide these benefits as part of the Value-Based Insurance Design program. This program lets Medicare try new ways to improve quality and access to care for enrollees of Medicare.

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

- If you receive "Extra Help" to pay your Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance, you may be eligible for other targeted supplemental benefits and/or targeted reduced cost sharing.

- Please go to the *Medical Benefits Chart* in Chapter 4 for further detail.

Important Benefit Information for Enrollees with Chronic Conditions

- If you are diagnosed with any of the following chronic condition(s) identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Members enrolled in VNS Health Total are special needs individuals with specific chronic conditions. Members enrolled in this plan may have co-morbid disabilities and comorbidities which also substantiate the complex needs of the membership.
  - Examples include, but are not limited to, the diagnosis of conditions such as heart failure, COPD, end-stage renal disease, dementia, cancer or stroke.
- Please go to the "Special Supplemental Benefits for the Chronically Ill" row in the below *Medical Benefits Chart* for further detail.

Please contact us to find out exactly which benefits you may be eligible for.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture Covered services include: up to 30 visits every year.	There is no copayment. No prior authorization required.

Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa)(5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,	There is no coinsurance, copayment or deductible for Medicare-covered acupuncture for lower back pain. Prior authorization required. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Acupuncture for chronic low back pain (Continued) • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You do not pay anything for Medicare covered one-way ambulance trips. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
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.

Services that are covered for you	**What you must pay** when you get these services
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. You are covered for a maximum of 2 one-hour sessions per day for up to 36 sessions up to 36 weeks.	You do not pay anything for Medicare-covered: • Cardiac rehabilitation services and • Intensive cardiac rehabilitation services Requires prior authorization. Contact your Care Team for more information.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation	You do not pay anything for Medicare-covered chiropractic visits. Requires prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding barium enemas, for which coinsurance applies. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening (Continued) Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	
Dental services Dental services are provided by Healthplex. In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. In addition, we cover: • 2 visits a year for Diagnostic Services • 2 visits a year for Restorative Services • 2 visits a year for Prosthodontics, • Other Oral/Maxillofacial Surgery Medicaid-covered dental services that include regular and routine dental services such as preventive dental checkups, cleaning, x-rays, fillings, dentures, dental implants and other services to check for any changes or abnormalities that may require treatment and/or follow-up care for you. You do not need a referral from your PCP to see a dentist. For dental-related questions, call Healthplex at 1-800-468-9868 (TTY: 1-800-662-1220), Monday – Friday, 8 am – 6 pm.	Maximum plan coverage is $3,000. There is no annual service category deductible for Medicare-covered dental benefits. You do not pay anything for Medicaid and Medicare-covered dental benefits

Services that are covered for you	**What you must pay** when you get these services
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of 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. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions. • Ascensia/Bayer Diabetes Care is the plan's chosen brand for diabetes monitoring and testing supplies when obtained at an in-network retail pharmacy. All other branded products will require plan approval for coverage.	You do not pay anything for Medicare-covered: • Diabetes monitoring supplies • Diabetes self-management training Therapeutic shoes or inserts May require prior authorization. Contact your Care Team for more information

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "durable medical equipment," see Chapter 12 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. Generally, VNS Health Total covers any DME covered by Original Medicare from the brands and manufacturers on this list. We will not cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. However, if you are new to VNS Health Total and are using a brand of DME that is not on our list, we will continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate for you after this 90-day period. (If you disagree with your doctor, you can ask him or her to refer you for a second opinion.)	You do not pay anything for Medicare or Medicaid-covered durable medical equipment items. Prior authorization required. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment (DME) and related supplies (Continued) If you (or your provider) don't agree with the plan's coverage decision, you or your provider may file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, see Chapter 9, *What to do if you have a problem or complaint (coverage decisions, appeals, complaints).*) The plan covers Medicaid durable medical equipment, including devices and equipment other than medical/ surgical supplies, enteral formula, and prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. DME must be ordered by a practitioner. No homebound prerequisite and includes non-Medicare DME covered by Medicaid (e.g. tub stool; grab bars); Medical/Surgical supplies, enteral/ parenteral formula and supplements, and hearing aid batteries.	

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. You are covered for up to $50,000 in emergency care and urgently needed services when you travel outside the United States and its territories. See "Worldwide Coverage for more information.	You do not pay anything for Medicare-covered emergency room visits. If you are admitted to the hospital within 24 hours of the emergency room visit, you pay $0 for the emergency room visit. 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.
Enhanced Disease Management This benefit that can provide you more support to take care of your health. Eligible members can participate to receive enhanced disease management. Services include: • Home visits by a nurse to evaluate health, social, and home safety needs • Help finding doctors and making appointments • Help taking medicine the right way • Connections to community resources	You pay $0. Contact your Care Team for details and eligibility.

Services that are covered for you	**What you must pay** when you get these services
Fitness You are covered for a health club membership through SilverSneakers®. This includes group exercise classes at participating health club facilities and online. This fitness membership program is designed for Medicare beneficiaries. For more information about this benefit you can visit the web site at silversneakers.com or call toll free 1-866-584-7389 (TTY: 711), Monday through Friday from 8 am to 8 pm.	There is no copayment for the services described in this section but there may be some limitations.
Flex Card The Flex Card is a $760 pre-loaded debit card benefit for the year. It may be used to help pay for utilities (**electric, gas, internet, and phone**) and items or services above the maximum covered amount for Dental (Diagnostic and Restorative Dental Services; Prosthodontics, Other Maxillofacial Surgery), Hearing (Hearing Aids - all types); or Vision (Eyeglasses (lenses and frames). Other types of services and goods are not eligible. During the first quarter of the year (January – March), you may use up to $193 to pay for eligible items or services. From April – December, you may use $63 per month to pay for eligible items or services. The card balance rolls over after each quarter but must be used by the end of the calendar year (January 1, 2024 through December 31, 2024.) Any unused balance on the card will be returned to the plan at the end of the calendar year or when you leave the plan.	$0 copayment You pay nothing for this benefit but there may be some limitations. Call your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Flex Card (Continued) Use your Flex Card like a debit card to pay your utility bills directly as long as you have the full amount of your bill available on your Flex Card when making payments. This includes any processing fee your utility company may charge. For example, if your electric bill is $50 and the electric company charges a $2.50 convenience fee to pay by card, make sure that you have at least $52.50 available on your Flex Card to pay your bill in full. Pay for your utilities as you do now and then request reimbursement for the cost of your utilities up to the amount of your available balance. For example, if your electric bill is $50 and you paid the bill with a check but the available balance on your Flex Card is $43, your reimbursement will be $43. If you enroll with VNS Health Total after 1/1/2024, the Flex benefit amount will be prorated. This means your benefit amount will be adjusted based on when your coverage becomes effective. For example, if your coverage begins on April 1st, then you will receive $567. Be aware that your Flex Card cannot be used for other kinds of items or services. Call us if you have questions about whether an item or service will be covered. It is not a credit card. You cannot convert the card to cash or loan it to other people.	

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs • Written, health education materials • Remote Access Technologies (including Web/Phone-based technologies and Nursing Hotline) Nursing Hotline, available 24 hours a day, 7 days a week. Call 1-866-783-1444 (TTY: 711).	You do not pay anything for the services described in this section.
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. You do not pay anything for: • One routine hearing exam every year • Two fitting evaluations for a supplemental hearing aid limited to one per ear (one right, one left) every three (3) years • Two supplemental hearing aids every three years • $1,500 plan coverage limit for supplemental hearing aids limited to $750 per ear (one right, one left) every three years Medicare and Medicaid hearing services and products are covered when medically necessary to alleviate disability caused by the loss or impairment of hearing.	You do not pay anything for Medicare-covered diagnostic hearing exams. You do not pay anything for Medicaid-covered hearing benefits. No prior authorization required.

Help with Certain Chronic Conditions

If you are diagnosed with heart failure stage four and Chronic Obstructive Pulmonary Disease (COPD), ejection fraction rates, or other serious illness, you may be eligible for the Palliative Care Program. If you are eligible for the program, it is available to you at no additional cost and is designed to provide an additional layer of support alongside your current medical treatment.

Palliative Care:
Palliative Care works to improve quality of life for you and your family. You may receive care through the Palliative Care Program if you have a serious illness. Care is provided by a team of doctors, nurse practitioners, nurses, social workers, nutritionists and other specially trained people. Your team will be created for you and will work with you, your Care Manager, your family and your doctors to help you live the best life possible.

If you are eligible and enroll in the Palliative Care Program, a member of your Care Team will call you at least monthly. Together with your Care Manager, you will plan the frequency of calls to provide you support and make sure your services are meeting your specific health needs, and discuss other resources you may need. You will receive the following support through care management services:

- Comprehensive care assessment in your home with a nurse practitioner who will coordinate your care with your primary care physician and Care Manager
- Care planning and goals of care discussions
- Access to social services and community resources
- Coordination with your Primary Care Physician

You do not pay anything for Medicare-covered services.

Services that are covered for you	**What you must pay** when you get these services
Help with Certain Chronic Conditions (Continued) If you become eligible for hospice during your enrollment in Palliative Care, and choose hospice, you may be eligible for transitional concurrent care. If eligible, you may continue curative treatments, such as palliative chemotherapy or hemodialysis, for up to 60 days after choosing an in-network hospice provider. Please see the "Hospice care" benefit for more information. If you become eligible for hospice during your enrollment in Palliative Care, and choose hospice, you may be eligible for transitional concurrent care. Transitional Concurrent Care (TCC) includes services you might need for continuing care needs, as medically appropriate, for the treatment of your terminal condition. These services help provide a transition to hospice care and may include a phasing out of specific curative treatment over time. TCC requires prior authorization and is available for up to 60 days after electing hospice, only if you elect an in-network provider. If eligible, you may continue curative treatments, such as palliative chemotherapy or hemodialysis, for up to 60 days after choosing an in-network hospice provider. Please see the "Hospice care" benefit for more information.	
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.

Services that are covered for you	**What you must pay** when you get these services
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	You do not pay anything for Medicaid or Medicare-covered home health visits. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring, restrictions may apply* • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier • Monitoring and remote monitoring services (covered under the professional services visit).	You do not have to pay for Medicare-covered home infusion therapy. Certain Part B drugs require prior authorization by the plan.

Services that are covered for you	**What you must pay** when you get these services
Hospice care Hospice is comprehensive, compassionate care focused on providing physical relief and emotional support for individuals with advanced illness. Its main goals are to ensure comfort, enhance quality of life and preserve dignity and choice, so that life can be lived as fully as possible. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: VNS Health Total will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. 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 and follow plan rules (such as if there is a requirement to obtain prior authorization):	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 VNS Health Total.

Services that are covered for you	**What you must pay** when you get these services
Hospice care (Continued) • If you obtain the covered services from a network provider and follow plan rules for obtaining services, 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 cost sharing according to the plan's rules described in Chapter 3, Section 1.2, "Basic rules for getting your medical care covered by the plan." For services that are covered by VNS Health Total but are not covered by Medicare Part A or B: VNS Health Total 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. *(As a member of the Total plan, you have $0 cost sharing).* For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 *(What if you're in Medicare-certified hospice)*. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	

Services that are covered for you	**What you must pay** when you get these services
Hospice (Continued) If you are eligible for hospice, and elect hospice, you may be eligible for Transitional Concurrent Care (TCC). TCC are services necessary to address continuing care needs, as medically appropriate, for the treatment of your terminal condition. These services help provide a transition to hospice care and may include a phasing out of specific curative treatment over time. TCC requires prior authorization and is available for up to 60 days after electing hospice, only if you elect an in-network hospice provider. If you are eligible but don't feel ready for hospice care, you can receive supportive services through our Palliative Care Program as described above in this chart under *Help with certain Chronic Conditions*.	
Hospice Care Support Allowance Hospice Care Support Allowance: If you are eligible for and elect hospice with an in-network hospice provider, you may be eligible for a $500 Hospice Care Support Allowance. The allowance is a supplemental benefit that allows for the purchase of goods or services that are not covered by your health plan's benefits. These goods or services should be related to providing comfort and improving your quality of life while receiving hospice care. Some examples include but are not limited to home and bathroom safety devices/modifications; support for caregivers of enrollees, etc.	$0 copay Hospice Care Support Allowance: If you are eligible for and elect hospice with an in-network hospice provider, you may be eligible for a $500 Hospice Care Support Allowance. Requires prior authorization. Contact your Care Team for more information on the full list of services covered by the plan.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • 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 • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, and COVID-19 vaccines.
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. Program provides inpatient hospital care for medically necessary services up to 365 days per year (366 in leap year). 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	May require prior authorization. Contact your Care Team for more information. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (Continued) • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we 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 VNS Health Total 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.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital care (Continued) • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *"Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!"* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-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.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient services in a psychiatric hospital *Behavioral and mental health services are provided by Carelon.* • Covered services include mental health care services that require a hospital stay • Medicare beneficiaries may only receive a 190-day lifetime limit for inpatient services in a psychiatric hospital. • Inpatient psychiatric hospital services count toward the 190-day lifetime limitation only if certain conditions are met. • The 190-day limit does not apply to inpatient psychiatric services furnished in a general hospital. • You are eligible for additional mental health benefits from Medicaid. • For behavioral- and mental health-related information, call Carelon at 1-866-317-7773 (TTY: 1-866-835-2755), Monday – Friday, 8 am – 8 pm. 7 days a week and 24 hours a day, for emergencies.	There is no annual service category deductible for services received at a network hospital. You do not pay anything for a Medicare-covered stay at a network hospital. You are covered for up to 190 days of inpatient hospital care in a lifetime. Inpatient hospital services count towards the 190-day lifetime limitation only if certain conditions are met. This limitation does not apply to inpatient psychiatric services furnished in a general hospital. May require prior authorization.

Services that are covered for you	**What you must pay** when you get these services
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay 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	If you receive services at a network hospital or skilled nursing facility, there is no deductible or copayment for the services listed in this section. May require prior authorization. Contact your Care Team for more information.

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

Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan
- 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 Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

We also cover some vaccines under our Part B and Part D prescription drug benefit.

Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.

There is no yearly deductible for Medicare Part B drugs.

You do not pay anything for Medicare Part B chemotherapy drugs and other Part B drugs.

May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	There is no coinsurance, copayment, or deductible for Opioid Treatment Program Services.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Other outpatient diagnostic tests	You do not pay anything for Medicare-covered outpatient diagnostic tests and therapeutic services and supplies. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called *"Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!"* This fact sheet is available on the Web at https://www.medicare.gov/sites/default/files/2021-10/11435-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.	You do not pay anything for Medicare-covered Outpatient Hospital Observation.

Services that are covered for you	**What you must pay** when you get these services
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/2021-10/11435-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.	There is no deductible or copayment for services received at a network hospital. Medicaid covers Medicare deductibles, copayments and coinsurance. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner, (NP), physician assistant, (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. For behavioral- and mental health related information, call Carelon at 1-866-317-7773 (TTY: 1-866-835-2755), Monday – Friday, 8 am – 8 pm. 7 days a week, 24 hours a day, for emergencies.	You do not pay anything for each Medicare-covered individual or group therapy visits. You do not pay anything for each Medicare-covered individual or group therapy visit with a psychiatrist. You do not pay anything for Medicare-covered partial hospitalization program services. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). As a dual eligible member, you are entitled to additional Medicaid-covered services. There are no coverage limits for medically necessary Outpatient Occupational Therapy (OT), Speech Therapy (ST) and Physical Therapy (PT) visits that are ordered by a doctor or other licensed professional. Please refer to Chapter 13 for benefits available under the VNS Health Total Medicaid Advantage Plus plan.	You do not pay anything for Medicare- or Medicaid-covered • Physical Therapy visits, • Speech Language Therapy visits, and • Occupational Therapy visits. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services Substance abuse services are provided in an office, clinic environment, an individual's home, or other locations appropriate for providing services. Services are provided by a doctor, clinical psychologist, clinical social worker, nurse practitioner, clinical nurse specialist, certified nurse-midwife, physician assistant, or other Medicare-qualified health care providers. Covered services include but are not limited to: • Initial and ongoing evaluation/assessment • Individualized plan of care with clear treatment • focus based on needs and response to treatment • Individual and group psychotherapy that focus • on behaviors associated with alcohol and/or drug use including lifestyle, attitudes, relapse prevention and coping skills • Family counseling and involvement as appropriate • Discharge planning that includes the identification of realistic discharge criteria A member may self-refer for one assessment from a network provider in a 12-month period.	You do not pay anything for each Medicare- or Medicaid-covered individual and group substance abuse outpatient treatment visit. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	You do not pay anything for each Medicare-covered ambulatory surgical center visit. You do not pay anything for each Medicare-covered outpatient hospital facility visit. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services

Over-the-Counter (OTC) and Grocery Card
VNS Health Total provides coverage of over-the-counter (OTC) and grocery items.
• Members will receive a catalog of approved products and items which includes information on how to access this benefit.
• You can also use this benefit to have meals or fresh produce delivered to your home. Call or visit the websites of these partner vendors to order.
  • www.MomsMeals.com or call (877)-347-3438 (TTY: 711) Monday through Friday from 7 am to 6 pm CT.
  • www.sunmeadow.com or call 1-866-575-2772 from 8 am to 6 pm ET
  • www.FarmboxRx.com or call (888) 416-3589 (TTY: 711) Monday through Friday from 9 am to 6 pm ET
• You can only use this benefit to purchase items for yourself. You cannot use this to buy items for your dependents or anyone else.
• Your benefit cannot be converted to cash.
• Your balance will not accumulate from month-to-month. Any unused amount will be returned to VNS Health Total.
• Some items are labeled “Dual Purpose” and can only be ordered if your doctor recommends that you use them.
• Some health products may be available to you through Medicaid using your Medicaid Benefit ID card.
Note: Please see the OTC and Grocery Card Catalog for a listing of covered items. The catalog also includes a listing of Non-Covered Health Items. If you do not have a copy, please call your Care Team and ask them to send you one.
	You pay $0.
	You are covered for up to $266 per month for over-the-counter (OTC) and grocery items.
	Please contact your Care Team for a complete list of eligible items and participating pharmacies and/or retailers.

Services that are covered for you	**What you must pay** when you get these services
Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	You do not pay anything for Medicare-covered services. May require prior authorization. Contact your Care Team for more information. Medicaid covers Medicare deductibles, copayments and coinsurances.

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP, if your doctor orders it to see if you need medical treatment • Certain additional telehealth services, including consultation, diagnosis and treatment by a physician or practitioner. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. o Telehealth services to diagnose, evaluate or treat symptoms of a stroke, regardless of your location. o Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location Please see Telehealth benefits for more information.	You do not pay anything for each primary care doctor visit for Medicare-covered benefits. You do not pay anything for each specialist visit for Medicare-covered benefits. You do not need a referral for visits to a PCP or specialist. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services

Physician/Practitioner services, including doctor's office visits (Continued)
• Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  o You have an in-person visit within 6 months prior to your first telehealth visit
  o You have an in-person visit every 12 months while receiving these telehealth services
  o Exceptions can be made to the above for certain circumstances
• Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
• Virtual check ins (for example, by phone or video chat) with your doctor for 5 – 10 minutes **if**:
  o You're not a new patient **and**
  o The check in isn't related to an office visit in the past 7 days **and**
  o The check in doesn't lead to an office visit within 24 hours or the soonest available appointment
• Evaluation of video and/or images you send to your doctor, and interpretation and follow up by your doctor within 24 hours **if**:
  o You're not a new patient **and**
  o The evaluation isn't related to an office visit in the past 7 days **and**
  o The evaluation doesn't lead to an office within 24 hours or the soonest available appointment
• Consultation your doctor has with other doctors by phone, internet, or electronic health record	

Services that are covered for you	**What you must pay** when you get these services
Physician/Practitioner services, including doctor's office visits (Continued) • 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).	
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs You are covered for up to 6 supplemental routine podiatry visits every year.	You do not pay anything for Medicare-covered podiatry visits. Medicare-covered podiatry visits are for medically necessary foot care. No prior authorization required.
Post Acute meals (Post-Discharge) • You can use this benefit to have meals delivered to your home after an acute inpatient hospital discharge. • You are covered for 28 meals over a 2-week period up to 3 inpatient hospital visits a year.	You do not pay anything for Post Acute Meals. No prior authorization required. Contact your Care Team for additional information.

Services that are covered for you	**What you must pay** when you get these services
Private Duty Nursing Covered when determined by the physician to be medically necessary. Nursing services can be provided through an approved certified home health agency, a licensed home care agency, or a private practitioner. Nursing services may be intermittent, part time or continuous and must be provided in an Enrollee's home in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan.	There is no copayment for each Medicaid-covered medically necessary service. Requires prior authorization. Contact your Care Team for more information.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for an annual PSA test.

Services that are covered for you	**What you must pay** when you get these services
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include but are not limited to: 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. Please refer to Chapter 13 for additional benefits available under the Medicaid Advantage Plus plan.	You do not pay anything for Medicare-covered: • Prosthetic devices • Medical supplies related to prosthetics, splints and other devices You do not pay anything for Medicaid-covered Prosthetic devices and related supplies and benefits. May require prior authorization. Contact your Care Team for more information. Medical supplies do not require prior authorization by the plan. No diabetic prerequisite for orthotics.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You do not pay anything for Medicare-covered pulmonary rehabilitation services. May require prior authorization. Contact your Care Team for more information.

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

Services that are covered for you	**What you must pay** when you get these services
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	**What you must pay** when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, Medicare Part B prescription drugs.	You do not pay anything for Medicare-covered services to treat kidney disease and conditions.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 12 of this document. Skilled nursing facilities are sometimes called SNFs.) Our plan covers up to 100 days in a skilled nursing facility. The plan also covers Medicaid-covered days beyond the Medicare 100-day limit. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need – you must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to get your care from a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.	There is no annual service category deductible. You do not pay anything for a Medicare or Medicaid-covered stay at a Skilled Nursing Facility. No prior hospital stay is required. A "benefit period" starts the day you go into the hospital or skilled nursing facility. It ends when you go for 60 days in a row without hospital or skilled nursing care. There is no limit to the number of benefit periods you can have. Requires prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (Continued) • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period; however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
Special Supplemental Benefits for the Chronically Ill See "Over-the-Counter (OTC) and Grocery Card" benefit for more information. For those members eligible for Special Supplemental Benefits for the Chronically Ill (SSBCI), VNS Health Total will allow the usage of the member's monthly Over-the-Counter (OTC) allowance towards an expanded list of approved items that include certain groceries. Special Supplemental Benefits for the Chronically Ill (SSBCI) combines the Over-the-Counter, Non-Prescription benefit to cover certain grocery items, which may only be used at selected pharmacies and/or retailers**.**	You pay $0. This benefit is combined with your Over-the-Counter (OTC) and Grocery Card to cover eligible grocery items.

Services that are covered for you	**What you must pay** when you get these services
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	You do not pay anything for Medicare-covered SET therapy. Requires prior authorization.

Services that are covered for you	**What you must pay** when you get these services
Telehealth Medicare telehealth services include certain medical or health services that are provided by an eligible provider who isn't at your location using an interactive 2-way telecommunications system (like real-time audio and video). Services included: • Urgently Needed Services; • Home Health Services; • Primary Care Physician Services; • Occupational Therapy Services; • Physician Specialist Services; • Individual Sessions for Mental Health Specialty Services; • Group Sessions for Mental Health Specialty Services; • Individual Sessions for Psychiatric Services; • Group Sessions for Psychiatric Services; • Physical Therapy and Speech-Language Pathology Services; • Opioid Treatment Program Services; • Outpatient Hospital Services; • Observation Services; • Ambulatory Surgical Center (ASC) Services; • Individual Sessions for Outpatient Substance Abuse; • Group Sessions for Outpatient Substance Abuse; • Kidney Disease Education Services; • Diabetes Self-Management Training	You do not pay anything for Medicare-covered telehealth. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Transportation • You are covered for scheduled round trips to and from plan-approved locations. • Non-emergency transportation services are covered Car service or ambulette is the mode of transportation Call the number below to schedule trips to and from medical appointments at least 48 hours in advance. 1-877-718-4219 (TTY: 711), 8 am – 8 pm, Monday – Friday.	You do not pay anything for Medicaid-covered transportation services. May require prior authorization. Contact your Care Team for more information.

Services that are covered for you	**What you must pay** when you get these services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. You are covered for up to $50,000 per year in emergency care and urgently needed services when you travel outside of the United States and its territories. See “Worldwide Coverage” for more information.	You do not pay anything for Medicare-covered urgently needed care visits.

Services that are covered for you	**What you must pay** when you get these services
Vision care *Vision services are provided by Superior Vision.* Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) You are also covered for: • One routine eye exam every year • One additional routine eye exam every 2 years. • One pair of eyeglasses (frames and lenses) or contact lenses, but not both, • $300 coverage limit for either one set of eyeglasses (frames and lenses) or contact lenses every year **Note:** A routine eye exam is to check vision, screen for eye disease, and/or update eyeglass or contact lens prescriptions.	You do not pay anything for the items and services listed in this section. Eye exams are covered every 12 months from the last date of service. There is no cost sharing for glaucoma tests. No prior authorization required.

Services that are covered for you	**What you must pay** when you get these services
Vision care (Continued) Medical necessity is required for all eye wear. Standard lenses include single, bifocal and trifocal lenses. Standard lenses do not include specialty lens such as transition, tints, progressives and polycarbonate. Standard contact lenses include extended daily wear, disposables, standard daily wear, toric or rigid gas permeable. For vision-related questions, call Superior Vision at 1-800-879-6901 TTY: 1-800-201-7165 Monday – Friday: 8 am – 9 pm (ET) Saturday: 11 am – 4:30 pm (ET)	
Welcome to Medicare preventive visit The plan covers the one-time **Welcome to Medicare** preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the **Welcome to Medicare** preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your **Welcome to Medicare** preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

Services that are covered for you	**What you must pay** when you get these services
Worldwide Coverage You are covered for up to a $50,000 plan limit every year for emergency care and urgently needed services outside the United States and its territories. If you receive emergency care or urgently needed care outside the United States, you are required to submit a form for reimbursement. Supporting documentation includes: • Member Name • Date of Service • Provider name, type, address and telephone • Description of services • Amount paid	Contact your Care Team for more information.

Section 2.2 Additional Medicaid-covered benefits for VNS Health Total Members

VNS Health Total is an Integrated Dual Eligible Special Needs Plan that combines Medicare coverage with Medicaid benefits including additional long-term care services, specifically designed for members who require nursing home level of care.

The following chart lists the additional Medicaid benefits and services available for VNS Health Total members. In most cases, you will use your VNS Health Total member identification (ID) card to receive the additional benefits described in this section. However, some benefits described in this section are only covered by New York State Fee-For-Service Medicaid, and not VNS Health Total. You will need to use your New York State issued Medicaid Card when accessing the services that are only covered by New York State Fee-For-Service Medicaid.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Adult Day Health Care Includes medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure activities, dental, pharmaceutical, and other ancillary services. Services furnished in approved SNF or extension site.	$0 copay May require prior authorization. Contact your Care Team for more information.
Adult Outpatient Mental Health Care ○ **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour. ○ **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Adult Outpatient Rehabilitative Mental Health Care ○ **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems. ○ **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community. ○ **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Adult Outpatient Rehabilitative Mental Health And Addiction Services For Members Who Meet Clinical Requirements. These are also known as CORE. ○ **Community Oriented Recovery and Empowerment (CORE) Services:** Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer or self-refer to CORE Services. ○ **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or returning to school; and using community resources. ○ **Community Psychiatric Supports and Treatment (CPST):** This service helps you manage symptoms through counseling and clinical treatment. ○ **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to: • live with health challenges and be independent, • help you make decisions about your own recovery, and • find natural supports and resources. ○ **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Adult Mental Health Crisis Services ○ **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services. ○ **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis. ○ **Crisis Residential Programs:** A short term residence that provides 24 hours per day services up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support the return to your community.	$0 copay No prior authorization required. Contact your Care Team for more information.
Adult Outpatient Addiction Services ○ **Opioid Treatment Centers (OTP)** are OASAS certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.	$0 copay May require prior authorization. Contact your Care Team for more information.
Adult Residential Addiction Services ○ **Residential Services** are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Adult Inpatient Addiction Rehabilitation Services ○ **State Operated Addiction Treatment Center's (ATC)** provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more. ○ **Inpatient Addiction Rehabilitation** programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use. ○ Inpatient Medically Supervised Detox programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Consumer Directed Personal Assistance Service A specialized service where a member or a person acting on a member's behalf, known as a designated representative, self directs and manages the member's personal care and other authorized services. Services include some or total assistance with personal hygiene, dressing and feeding, assistance in preparing meals and housekeeping as well as home health aide and nursing tasks. This is provided by personal assistant chosen and directed by the member or a designated representative.	$0 copay May require prior authorization. Contact your Care Team for more information.
Home Delivered and Congregate Meals Meals provided at home or in congregate settings, e.g., senior centers to individuals unable to prepare meals or have them prepared.	$0 copay May require prior authorization. Contact your Care Team for more information.
Medical Social Services Medically necessary assessment, arranging and providing aid for social problems related to maintaining an individual at home.	$0 copay May require prior authorization. Contact your Care Team for more information.
Nutrition Assessment of nutritional status/needs, development and evaluation of treatment plans, nutritional education, in-service education, and includes cultural considerations.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Personal Care Services Medically necessary assistance with activities such as personal hygiene, dressing and feeding, and nutritional and environmental support function tasks. Personal care services require a physician's order, prior approval, and must be medically necessary.	$0 copay May require prior authorization. Contact your Care Team for more information.
Personal Emergency Response Services (PERS) Electronic device that enables individuals to secure help in a physical, emotional or environmental emergency.	$0 copay May require prior authorization. Contact your Care Team for more information.
Private Duty Nursing This type of service provides continuous nursing services in your home or place of residence. This is in accordance with the ordering physician, registered physician assistant or certified nurse practitioner's written treatment plan. Private duty nursing services must be provided by a person possessing a license and current registration from the New York State Education Department to practice as a registered professional nurse or licensed practical nurse.	$0 copay May require prior authorization. Contact your Care Team for more information.
Social and Environmental Supports Services and items to support member's medical need. May include home maintenance tasks, homemaker/chore services, housing improvement, and respite care.	$0 copay May require prior authorization. Contact your Care Team for more information.

Additional Medicaid Services that are covered for you	**What you must pay** when you get these services
Social Day Care Structured, comprehensive program which provides functionally impaired individuals with socialization; supervision and monitoring; personal care; and nutrition in a protective setting during any part of the day, but for less than a 24-hour period. Additional services may include and are not limited to maintenance and enhancement of daily living skills, transportation, care giver assistance and case coordination and assistance.	$0 copay May require prior authorization. Contact your Care Team for more information.

SECTION 3 What services are covered outside of VNS Health Total*?*

Section 3.1 Services *not* covered by VNS Health Total

The following services are not covered by VNS Health Total but are available through Medicaid:

Medicaid Services Not Covered by VNS Health Total ***The following benefits and services are not covered by VNS Health Total, but are covered by Fee-For-Service Medicaid. Please present your New York State issued Medicaid card to access these benefits.**	
Certain Mental Health Services, including o Day Treatment o Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units)	$0 copay
Certified Community Behavioral Health Clinics (CCBHC)	$0 copay
Crisis Intervention Services for Youth ages 18-20	$0 copay
CSS (Community Support Services)	$0 copay
Directly Observed Therapy for Tuberculosis Disease	$0 copay
Health Home (HH) and Health Home Plus (HH+) Care Management services	$0 copay
Office for People with Developmental Disabilities (OPWDD)	$0 copay
Out of network Family Planning services under the direct access provisions	$0 copay
Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs	$0 copay

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

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

This section tells you what services are excluded by Medicare.

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		• Available for people with chronic low back pain under certain circumstances.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined 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.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Fees charges for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition**	
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic Shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or television.	**Not covered under any condition**	
Private room in a hospital		Covered only when medically necessary
Reversal of Sterilization procedures and/or non-prescription contraceptive supplies.	**Not covered under any condition**	
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.
Services considered not reasonable and necessary according to Original Medicare	**Not covered under any condition**	

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

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We have included 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 your Care Team and ask for the LIS Rider. (Phone numbers for your Care Team are printed on the back cover of this document.)

SECTION 1 Introduction

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

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

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy 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*").
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references.(See Section 3 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 Use a network pharmacy

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

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider and Pharmacy Directory*, visit our website (*vnshealthplans.org/providers*), and/or call your Care Team.

You may go to any of our network pharmacies. Some of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider and Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

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

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

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you are in 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 your Care Team.
- 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 *Provider and Pharmacy Directory* or call your Care Team.

Section 2.3 Using the plan's mail-order service

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

Our plan's mail-order service allows you to order **up to a 100-day supply,** except for Specialty drugs, which are limited to a 30-day supply.

To get order forms and information about filling your prescriptions by mail, please review the information included in your Welcome Kit or call your Care Team to

request a copy of the mail order form. If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually, a mail-order pharmacy order will be delivered to you in no more than **10** days. However, sometimes your mail order may be delayed. If there is a delay in receiving your mail order prescription(s), please call your Care Team.

To make sure 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 by including your phone number on the mail order form.

New prescriptions the pharmacy receives directly from your doctor's office.
After the pharmacy receives a prescription from a health care provider, it will contact you to see if you want the medication filled immediately or at a later time. This will give you the opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if needed, allow you to stop 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 whether to ship, delay, or stop the new prescription.

Refills on mail-order prescriptions. For refills, please contact your pharmacy 10 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs at the mail-order cost-sharing amount. Other retail pharmacies may not agree to the mail-order cost-sharing amounts. In this case you will be responsible for the difference in price. Your *Pharmacy and*

Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call your Care Team for more information.

2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

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

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. **Please check first with your Care Team** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

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

- A member cannot obtain a covered Part D drug in a timely manner within the plan's service area because there is no network pharmacy available within a reasonable driving distance.
- A Part D drug that has been dispensed by an out-of-network institution-based pharmacy while a member is in the emergency room.
- A member, while out of the service area, becomes ill or runs out of his/her medications and cannot access a network pharmacy.
- Filling a prescription for a covered Part D drug and that drug is not regularly stocked at an accessible network pharmacy.

In these situations, **please check first with your Care Team** to see if there is a network pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription.

You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

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

The Drug List includes the drugs covered under Medicare Part D.

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

The "Drug List" includes brand name drugs, and biosimilar.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. On the "Drug List", when we refer to "drugs," this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug and

biological products usually cost less. There are generic drug substitutes available for many brand name drugs. There are biosimilar alternatives for some biological products.

Over-the-Counter Drugs

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

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". In some cases, you may be able to obtain a drug that is not on the "Drug List". For more information, please see Chapter 9.

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

You have three ways to find out:

1. Check the most recent "Drug List" we provided electronically. (Please note: The "Drug List" we provide includes information for the covered drugs that are most commonly used by our members.
2. Visit the plan's website vnshealthplans.org/formulary. The "Drug List" on the website is always the most current.
3. Call your Care Team to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (www.medimpact.com) or by calling your Care Team). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 We send you reports that explain payments for your drugs and which payment stage you are in

Section 4.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)

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

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- 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.

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

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

Section 4.2 Help us keep our information about your drug payments up to date

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

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

  If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have any questions, please call us at Member Services. Be sure to keep these reports.

SECTION 5 There are restrictions on coverage for some drugs

Section 5.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. If a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option.

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

Section 5.2 What kinds of restrictions?

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

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

Restricting brand name drugs or original biological products when a generic version or interchangeable biosimilar is available

Generally, a "generic" drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **In most cases, when a generic version or interchangeable biosimilar of a brand name drug or original biological product is available, our network pharmacies will provide you the generic version or interchangeable biosimilar instead of the brand name drug or original biological products.**

Getting plan approval in advance

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

Trying a different drug first

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

Quantity limits

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

SECTION 6 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

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

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

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.

Section 6.2 What can you do if your drug is not on the Drug List or if the drug is restricted in some way?

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

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

You may be able to get a temporary supply

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

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

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

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

- If you experience a change in your level of care, such as you 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, but you are past the first 90 days of membership in our plan, we will cover a one-time temporary supply for up to 31 days when you go to 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 limited.

For questions about a temporary supply, call your Care Team.

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

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call your Care Team to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

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

SECTION 7 What if your coverage changes for one of your drugs?

Section 7.1 The Drug List can change during the year

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

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

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

Section 7.2 What happens if coverage changes for a drug you are taking?

Information on changes to drug coverage

When changes to the "Drug List" occur, we post information on our website about those changes. We also update our online "Drug List" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug replaces a brand name drug on the "Drug List" (or we add new restrictions to the brand name drug or both)**
    - 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. The generic drug will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. We may decide to keep the brand name drug on our "Drug List", but immediately move it to a

higher cost-sharing tier or add new restrictions or both when the new generic is added.

- We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. 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). 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.
- 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.

- **Unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the "Drug List". If you are taking that drug, we will tell you 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 example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost-sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 30-day refill of the drug you are taking at a network pharmacy.
  - After you receive notice of the change, you should work with your prescriber to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.

- 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.

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

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

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

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

If any of these changes happen for a drug you are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), 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 restrictions to your use of the drug.

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

SECTION 8 What types of drugs are *not* covered by the plan?

Section 8.1 Types of drugs we do not cover

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

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

9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself.

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan 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.
- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs listed below are not covered by Medicare

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

If you are receiving Extra Help to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact

your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 9 Filling a prescription

Section 9.1 Provide your membership information

To fill your prescription, provide your plan membership information, which can be found on your membership card, at the network pharmacy you choose. The network pharmacy will automatically bill the plan for your drug.

Section 9.2 What if you don't have your membership information with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**.

SECTION 10 Part D drug coverage in special situations

Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

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

Section 10.2 What if you're a resident in a long-term care (LTC) facility?

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

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

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

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

Section 10.3 What if you're in Medicare-certified hospice?

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

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

SECTION 11 Programs on drug safety and managing medications

Section 11.1 Programs to help members use drugs safely

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

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

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

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

Section 11.2 Drug Management Program (DMP) to help members safely use their opioid medications

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

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

If we plan on limiting how you may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we will send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal. You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 11.3 Medication Therapy Management (MTM) program to help members manage their medications

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

Some members who take medications for different medical conditions and have high drug costs, or are in a DMP to help members use their opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your

costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will receive information on the safe disposal of prescription medications that are controlled substances.

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

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

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

How can you get information about your drug costs?

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. Because you are in the "Extra Help" program, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We have included 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 your Care Team and ask for the LIS Rider. (Phone numbers for your Care Team are printed on the back cover of this document.

CHAPTER 7:

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

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

Our network providers bill the plan directly for your covered services and drugs – you should not receive a bill for covered services or drugs. If you get a bill for medical care or drugs you have received, you should send this bill to us so that we can pay it. When you send us the bill, we will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

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

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

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

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

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

Network providers should always bill the plan directly. But sometimes they make mistakes, and ask you to pay for your services.

- Whenever you get a bill from a network provider, 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, send us the bill along with documentation of any payment you have made. You should ask us to pay you back for your covered services.

3. If you are retroactively enrolled in our plan

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

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

4. 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.

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

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

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

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

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **For Part C (Medical Claims)** mail your request for payment together with any bills or receipts to us at this address:

VNS Health
Health Plans - Claims
PO Box 4498
Scranton, PA 18505

You must submit your claim to us within 365 days or one year of the date you received the service, or item.

For Part D (Prescription drug claims) Mail your request for payment together with any bills or receipts to us at this address:

MedImpact Healthcare Systems, Inc.
PO Box 509098
San Diego, CA 92150-9108
Fax: 858-549-1569
E-mail: Claims@Medimpact.com

You must submit your claim to us within 3 years of the date you received the service, item, or drug.

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

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for the service. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay the care or drug. We will send you a letter explaining the reasons why we are not sending the payment and your rights to appeal that decision.

CHAPTER 8:
Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. This document may be available in Spanish and Chinese. 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 your Care Team.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with your Care Team at 1-866-783-1444 (TTY users call 711), 8 am to 8 pm, 7 days a week. 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 at 1-800-368-1019 or TTY 1-800-537-7697.

1.1 Nosotros debemos brindarle información en una forma que funcione para usted (en idiomas diferentes al Inglés, en braille, en letra legible u otros formatos alternativos, etc.)

Para obtener información en una forma que funcione para usted, comuníquese con el Servicio de Atención al Miembro (los números de teléfono se encuentran en la contraportada de este folleto).

Nuestro plan posee personas y servicios de interpretación gratuitos disponibles para responder preguntas a miembros discapacitados y que no hablen el idioma inglés. Este documento también está disponible en idioma español y chino. También podemos darle información en braille, en letra legible u otros formatos alternativos sin costo alguno si lo necesita. Debemos brindarle información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. Para obtener información en una forma que funcione para usted, comuníquese con el Servicio de Atención al Miembro (los números de teléfono se encuentran en la contraportada de este folleto).

Si tiene problemas para recibir información acerca de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja al Servicio de Atención al Miembro al 1-866-783-1444 (los usuarios de TTY deben llamar al 711), de 8:00 a. m. a 8:00 p. m., los 7 días de la semana. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles. Puede encontrar la información de contacto en esta Evidencia de cobertura o en esta correspondencia, o puede comunicarse con el Servicio de Atención al Miembro para obtener información adicional.

1.1 我們必須以適合您的方式提供信息（包括英語以外的其他語言、盲文、大號字體、或其他各式等）

如需我們以適合您的方式提供信息，請致電會員服務部（電話號碼印於本冊封底）。

我們的計劃配有專員及免費的翻譯服務，可回答殘障會員和不說英語的會員提出的問題。我們提供西班牙文和中文版書面資料。我們也可以盲文、大號字體印刷版或您需要的其他可選形式免費向您提供資訊。我們必須以方便您查閱及適合您的形式為您提供計劃福利的相關資訊。如需我們以適合您的方式提供資訊，請致電會員服務部（電話號碼印在本手冊封底）。

如果您無法從我們的計劃獲得方便您查閱和適合您的計劃資訊的方式，請致電會員服務部 1-866-783-1444 每週七天，早上 8 點至晚上 8 點 (聽障人士請致電 711) 提出申訴。您亦可撥打 1-800-MEDICARE (1-800-633-4227) 向 Medicare 提交投訴，或直接向民權辦公室提出投訴。聯絡資訊包含在本承保範圍說明書或本郵件中，或您可聯絡會員服務部獲得其他資訊。

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

You have the right to choose a primary care provider in the plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral. We do not require you to get referrals to go to network providers.

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

NOTICE OF PRIVACY PRACTICES of VNS Health OHCA

THIS JOINT HIPAA NOTICE OF PRIVACY PRACTICES (THE "NOTICE") DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Who Will Follow this Notice?

The VNS Health Organized Health Care Arrangement (the "VNS Health OHCA," "we" or "us"), is an organized health care arrangement that is comprised of the entities listed below (each an "OHCA Member" and collectively, the "OHCA Members"). For purposes of our privacy practices, we are considered one single entity.

Visiting Nurse Service of New York Home Care II d/b/a VNS Health Home Care
New Partners, Inc. d/b/a VNS Health Personal Care
VNS CHOICE d/b/a VNS Health Health Plans
Visiting Nurse Service of New York Hospice Care d/b/a VNS Health Hospice Care
Medical Care at Home, P.C.
VNSNY Care Management IPA, Inc.

The VNS Health OHCA was formed for the primary purpose of improving the quality of care provided to you. Membership in the VNS Health OHCA permits the OHCA Members to share medical information amongst ourselves to manage joint operational activities. In order to provide care or pay for your services, the OHCA Members must collect, create and maintain health information about you, which includes any individually identifiable information that we obtain from you or others that relates to your past, present or future physical or mental health, the health care you have received, or payment for your health care. Each OHCA Member is required by the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, as amended from time to time (collectively, "HIPAA") to maintain the privacy and security of this information.

This Notice describes how OHCA Members use and disclose your health information and explains certain rights you have regarding this information. Each OHCA Member is required by law to provide you with this Notice, and we will comply with the terms as stated. The privacy practices in this Notice will be followed by all OHCA Members, including their workforce members and business associates. We will only use or disclose your health information as described in this Notice, unless you notify us in writing, at the address provided below, that we have permission to use your health information other than as described in this Notice. This Notice does not alter the independent status of any OHCA Member nor does it make any of the OHCA Members jointly responsible for the negligence, mistakes, or violations of any of the other OHCA Members.

How VNS Health OHCA Uses and Discloses Your Health Information
The OHCA Members protect your health information from inappropriate use and disclosure. The OHCA Members will use and disclose your health information for only the purposes listed below:

1. Uses and Disclosures for Treatment, Payment and Health Care Operations. We may use and disclose your health information in order to provide your care or treatment, obtain payment for services provided to you and in order to conduct our health care operations as detailed below.

    a. Treatment and Care Management. We may use and disclose health information about you to facilitate treatment provided to you by the OHCA Members and coordinate and manage your care with other health care providers. For example, your OHCA Member clinician may discuss your health condition with your doctor to plan the clinical services you receive at home. We may also leave health information in your home for the purpose of keeping other caregivers informed of needed information.
    b. Payment. We may use and disclose health information about you for our own payment purposes and to assist in the payment activities of other health care providers. Our payment activities include, without limitation, determining your eligibility for benefits and obtaining payment from insurers that may be responsible for providing coverage to you, including Federal and State entities.
    c. Health Care Operations. We may use and disclose health information about you to support our functions, which include, without limitation, care management, quality improvement activities, evaluating our own performance and resolving any complaints or grievances you may have. We may also use and disclose your health information to assist other health care providers in performing health care operations.

2. Uses and Disclosures Without Your Consent or Authorization. We may use and disclose your health information without your specific written authorization for the following purposes:

    a. As Required by Law. We may use and disclose your health information as required by any applicable state, federal and local law.
    b. Public Health Activities. We may disclose your health information to public

authorities or other agencies and organizations conducting public health activities, such as preventing or controlling disease, injury or disability, reporting births, deaths, child abuse or neglect, domestic violence, potential problems with products regulated by the Food and Drug Administration or communicable diseases.

c. Victims of Abuse, Neglect or Domestic Violence. We may disclose your health information to an appropriate government agency if we believe you are a victim of abuse, neglect, domestic violence and you agree to the disclosure or the disclosure is required or permitted by law. We will let you know if we disclose your health information for this purpose, unless we believe that advising you or your caregiver would place you or another person at risk of serious harm.
d. Health Oversight Activities. We may disclose your health information to federal or state health oversight agencies for activities authorized by law such as audits, investigations, inspections and licensing surveys.
e. Judicial and Administrative Proceedings. We may disclose your health information in the course of any judicial or administrative proceeding or in response to a subpoena, discovery request or other lawful purpose.
f. Law Enforcement Purposes. We may disclose your health information to a law enforcement agency to respond to a court order, warrant, summons or similar process, to help identify or locate a suspect or missing person, to provide information about a victim of a crime, a death that may be the result of criminal activity, or criminal conduct on our premises, or, in emergency situations, to report a crime, the location of the crime or the victims, or the identity, location or description of the person who committed the crime.
g. Deceased Individuals. We may disclose your health information to a coroner, medical examiner or a funeral director as necessary and as authorized by law.
h. Organ or Tissue Donations. We may disclose your health information to organ procurement organizations and similar entities for the purpose of assisting them in organ or tissue procurement, banking or transplantation.
i. Research. We may use or disclose your health information for research purposes, such as studies comparing the benefits of alternative treatments received by our patients or investigations into how to improve our care delivery. We will use or disclose your health information for research purposes only with the approval of our Institutional Review Board (“IRB”), which must follow a special approval process. Before permitting any use or disclosure of your health information for research purposes, our IRB will balance the needs of the researchers and the potential value of their research against the protection of your privacy. When required, we will obtain a written authorization from you prior to using your health information for research.
j. Health or Safety. We may use or disclose your health information to prevent or lessen a serious or imminent threat to the health or safety of you or the general public. We may also disclose your health information to public or private disaster relief organizations such as the Red Cross or other organizations participating in bio-terrorism countermeasures.
k. Specialized Government Functions. We may use or disclose your health information to provide assistance for certain types of government activities. If you are a member of the armed forces of the United States or a foreign country,

we may disclose your health information to appropriate military authority as is deemed necessary. We may also disclose your health information to federal officials for lawful intelligence or national security activities.

l. Workers' Compensation. We may use or disclose your health information as permitted by the laws governing the workers' compensation program or similar programs that provide benefits for work-related injuries or illnesses.

m. Individuals Involved in Your Care. We may disclose your health information to a family member, other relative or close personal friend assisting you in receiving health care services. If you are available, we will give you an opportunity to object to these disclosures, and we will not make these disclosures if you object. If you are not available, we will determine whether a disclosure to your family or friends is in your best interest, taking into account the circumstances and based upon our professional judgment.

n. Communications Regarding Appointments, Information and Services. We may contact you or your designated personal representative via email, as well as text messages or telephone (including cell phone) calls using automated or prerecorded messages to provide appointment and visit reminders, patient satisfaction surveys, program welcome emails and newsletters, or information about treatment alternatives or other health-related services. The frequency of these messages will vary. You have the right to opt out of receiving calls and text messages by following the applicable unsubscribe or opt-out instructions provided, by texting "STOP" or by contacting VNS Health or its designated third party vendor. Standard message and data rates may apply. If you no longer wish to receive emails, you may click on the hyperlink titled "Unsubscribe" at the bottom of any email sent to you by VNS Health, and then follow the directions to unsubscribe from the email. Your consent to receive phone calls, text messages and/or emails is not a condition of your obtaining other health care services from VNS Health. Please note that communications transmitted via unencrypted email, text message or over an open network may be inherently unsecure, and there is no assurance of confidentiality for information communicated in this manner. Additionally, emails and text messages have inherent privacy risks, especially when access to your computer or mobile device is not password protected.

o. Fundraising. As a not-for-profit health care organization, our parent agency, VNS Health, may identify you as a patient for purposes of fundraising and marketing. You have the right to opt out of receiving such fundraising communications by contacting us at the email address or phone number we provide in the fundraising communication or by filling out and mailing back a preprinted, prepaid postcard contained in the fundraising communication.

p. Incidental Uses and Disclosures. Incidental uses and disclosures of your health information sometimes occur and are not considered to be a violation of your rights. Incidental uses and disclosures are by-products of otherwise permitted uses or disclosures which are limited in nature and cannot be reasonably prevented.

q. Organized Health Care Arrangement. We may share your health information amongst our OHCA Members to perform health care operations, unless otherwise limited by another law or regulation. For example, your health

information may be shared across the VNS Health OHCA in order to assess quality, effectiveness, and cost of care.

r. Personal Representative. We may disclose your health information to your authorized personal representative, such as your lawyer, administrator, executor health care proxy or another authorized person responsible for you or your estate.

s. Business Associates. We may disclose your health information to other companies or individuals, known as "Business Associates," who provide services to us. For example, we may share your health information with a company that provides billing or care management services on our behalf. Our Business Associates are required to protect the privacy and security of your health information and notify us of any improper use or disclosure of your health information.

t. De-identification and Partial De-identification. We may de-identify your health information by removing identifying features as determined by law to make it extremely unlikely that the information could identify you, and may use or disclosure such de-identified information. We may also use and disclose "partially de- identified" health information about you for research, public health or health care operations purposes if the person or entity who will receive the information signs an agreement to protect the privacy of the information as required by federal and state law. Partially de-identified health information will not contain any information that would directly identify you (such as your name, street address, social security number, phone number, fax number, electronic mail address, website address or license number).

3. Health Information Exchanges. We participate in secure HIEs, such as those operated by Healthix and Bronx RHIO. HIEs help coordinate patient care efficiently by allowing health care providers involved in your care to share information with each other in a secure and timely manner. If you provide consent, OHCA Members may use, disclose and access your health information via the HIEs in which the VNS Health OHCA participates for purposes of treatment, payment and healthcare operations.

4. Special Treatment of Certain Records. HIV-related information, genetic information, alcohol and/or substance abuse records, mental health records and other specially protected health information may enjoy certain special confidentiality protections under applicable state and federal law. Any disclosures of these types of records will be subject to these special protections. Specifically, if applicable to you, substance use disorder patient records protected pursuant to 42 C.F.R. Part 2 and will not be shared amongst the OHCA Members, unless such disclosure is permitted by Part 2.

5. Obtaining Your Authorization for Other Uses and Disclosures. Certain uses and disclosures of your health information will be made only with your written authorization, including uses and/or disclosures: (a) of psychotherapy notes (where appropriate); (b) for marketing purposes; and (c) that constitute a sale of health information under the HIPAA Privacy Rule. The OHCA Members will not use or disclose your health information for any purpose not specified in this Notice, other

than those uses or disclosures otherwise permitted or required by law, unless we obtain your express written authorization or the authorization of your legally appointed representative. If you give us your authorization, you may revoke it at any time, in which case we will no longer use or disclose your health information for the purpose you authorized, except to the extent we have relied on your authorization to provide your care. A revocation of authorization must be submitted to the VNS Health Privacy Officer at the address provided at the end of this Notice.

6. Children's and Family Services or Behavioral Health Services. If you decide to receive services from other VNS Health programs, such as Children's and Family Services or Behavioral Health services, you will be informed of specific privacy practices that relate to those programs in addition to the practices contained in this notice.

Your Rights Regarding your Health Information
You have the following rights regarding your health information:

1. Right to Inspect and Copy. You, or your authorized representative, have the right to inspect or request a copy of health information about you that we maintain. Requests should be sent to the Medical Records Department via email to records.requests@vnshealth.org. Your request should describe the information you want to review and the format in which you wish to review it. If we maintain an electronic health record containing your information, you have the right to request that we send a copy of your health information in electronic format to you or a third party that you identify. We may refuse to allow you to inspect or obtain copies of this information in certain limited cases. We may charge you a reasonable, cost-based fee. We may also deny a request for access to health information under certain circumstances if there is a potential for harm to yourself or others. If we deny a request for access for this purpose, you have the right to have our denial reviewed in accordance with the requirements of applicable law, by filing a request for review with the VNS Health Privacy Officer.

2. Right to Request Amendments. You have the right to request changes to any health information we maintain about you if you state a reason why this information is incorrect or incomplete. Your request must be in writing and must explain why the information should be corrected or updated. We may deny your request under certain circumstances and provide a written explanation.

3. Right to an Accounting of Disclosures. You have the right to receive a list of the disclosures of your health information by each of the OHCA Members. The list will not include disclosures made for certain purposes including, without limitation, disclosures for treatment, payment or health care operations or disclosures you authorized in writing. Your request should specify the time period covered by your request, which cannot exceed six years. The first time you request a list of disclosures in any 12-month period, it will be provided at no cost. If you request additional lists within the 12- month period, we may charge you a nominal fee.

4. Right to Request Restrictions. You have the right to request restrictions on the ways

which we use and disclose your health information. While we will consider all requests for additional restrictions carefully, an OHCA Member is not required to comply with your request except for restrictions on uses or disclosures for the purpose of carrying out payment or health care operations, where you have paid the bill "out-of-pocket" in full. If we do agree to a requested restriction, we will not disclose your health information in accordance with the agreed-upon restriction.

5. Right to Request Confidential Communications. You have the right to ask us to send health information to you in a different way or at a different location. Your request for an alternate form of communication should also specify where and/or how we should contact you.

6. Right to Receive Notification of Breach. You have the right to receive a notification, in the event that there is a breach of your unsecured health information, which requires notification under the HIPAA Privacy Rule.

7. Right to Paper Copy of Notice. You have the right to receive a paper copy of this Notice at any time. You may obtain a paper copy of this Notice, by writing to the VNS Health Privacy Officer. You may also print out a copy of this Notice by going to our website at vnshealth.org.

8. Choose Someone to Act for You. If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure that person has this authority and can act for you before we take any action.

9. HIE Opt-Out. You have the right to opt-out of the disclosure of your health information to or via an HIE. However, information that is sent to or via an HIE prior to processing your opt- out may continue to be maintained by, and be accessible through, the HIE.

10. Complaints**.** If you believe your privacy rights have been violated you have the right to file a complaint with the VNS Health Privacy Officer. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services ("HHS"). We will provide you with the address to file your complaint with HHS upon request. You will not be penalized or retaliated against by the OHCA Members, or their parent, VNS Health, for filing a complaint.

Breach Notification. We are required by law to notify you following the discovery that there has been a breach of your unsecured health information, unless we determine that there is a low probability that the privacy or security of your health information has been compromised. You will be notified in a timely manner, no later than sixty (60) days after discovery of the breach, unless state law requires notification sooner.

Questions. If you have any questions or comments about our privacy practices or this Notice, or if you would like a more detailed explanation about your privacy rights, please contact the VNS Health Privacy Officer using the contact information provided at the end of this Notice.

Changes to this Notice. The OHCA Members may change the terms of this Notice of

Privacy Practices at any time. If the terms of the Notice are changed, the new terms will apply to all of your health information, whether created or received by VNS Health OHCA before or after the date on which the Notice is changed. Any updates to the Notice will be made available on vnshealth.org.

Contact Information. When communicating with us regarding this Notice, our privacy practices or your privacy rights, please contact the VNS Health Privacy Officer using the following contact information: VNS Health, 220 East 42nd Street, 6th Floor, New York, NY 10017; Attn: Privacy Officer; Telephone: (212) 609-7470; Email: hipaaandprivacy.team@vnshealth.org
Effective Date: 11/01/2020
Last Reviewed & Revised: 8/29/2023

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

As a member of VNS Health Total, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call your Care Team:

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

restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

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

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

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

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

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

The legal documents that you can use to give your directions in advance in these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

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

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

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

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

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

What if your instructions are not followed?

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

The contact information is:

The New York Medicaid
Office of the Commissioner
Empire State Plaza Corning Tower
Albany, NY 11237

Telephone Number: 1-800-541-2831

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

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

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

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

If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697 or call your local Office for Civil Rights.

Is it about something else?

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

- You can **call your Care Team**.

- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).
- You can call the **New York Medicaid** at 1-800-541-2831. TTY users should call 711.
- Or, you can call the **New York State Office for the Aging (Ombudsman Program)** at 1-800-342-9871. TTY users should call 711.

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 your Care Team**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication *"Medicare Rights & Protections."* (The publication is available at: 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 1-877-486-2048).

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

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
  - Chapters 5 and 6 give the details about your Part D prescription drug coverage.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card and your Medicaid card whenever you get your medical care or Part D prescription drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
    - You must continue to pay your Medicare premiums to remain a member of the plan.
    - If you are required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to remain a member of the plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

SECTION 3 Our plan has been approved by the National Committee for Quality Assurance

VNS Health Total has been approved by the National Committee for Quality Assurance (NCQA) to operate as a Special Needs Plan (SNP) until 2025 based on a review of the VNS Health Total Model of Care.

CHAPTER 9:

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

SECTION 1 Introduction

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

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

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints;** also called grievances.

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

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

Section 1.2 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 make things easier, this chapter:

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

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

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

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

Medicare

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

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You also can visit the Medicare website (www.Medicare.gov).

You can get help and information from Medicaid

If you have any questions about your Medicaid benefits, call the New York Medicaid.

New York Medicaid – Contact Information
Phone: 1-800-541-2831 TTY: 711 (This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking)

Address:
New York Medicaid
Office of the Commissioner
Empire State Plaza Corning Tower
Albany, NY 11237

Website: www.health.ny.gov.

You may also contact the Quality Improvement Organization Livanta at 1-866-815-5440. TTY is 1-866-868-2289.

Address:

Livanta
BFCC-QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701

SECTION 3 Understanding Medicare and Medicaid complaints and appeals in our plan

You have Medicare and get assistance from Medicaid. Information in this chapter applies to **all** of your Medicare and **most** of your Medicaid benefits. For most of your benefits, you will use one process for your Medicare benefits and your Medicaid benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes are not combined. In those situations, you use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4** of this chapter, "Step-by-step: How a Level 2 appeal is done."

PROBLEMS ABOUT YOUR BENEFITS

SECTION 4 Coverage decisions and appeals

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

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

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

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

Coverage decisions and appeals deal with problems related to your benefits and coverage for medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as **medical care**. You use the coverage decision and appeals process. 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 prior to receiving benefits

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

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not

covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

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

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

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2. The Level 2 appeal is conducted by the Office of Administrative Hearings. They are not connected to us.

- Your case will be automatically sent to the Office of Administrative Hearings for a Level 2 appeal – you do not have to do anything. The Office of Administrative Hearings will mail you a notice to confirm they received your Level 2 appeal.
- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

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

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

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

- You **can call your Care Team**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call your Care Team and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at vnshealthplans.org.)
  - For medical care, your doctor or other health care provider 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
  - If your doctor or other health provider asks that a service or item that you are already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call your Care Team and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at

www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at vnshealthplans.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form 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 Office of Administrative Hearings to review our decision to dismiss your appeal.

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

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

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

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

If you're not sure which section you should be using, call your Care Team. You can also get help or information from government organizations such as your SHIP.

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

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

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

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

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

NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, hospice care, or Comprehensive Outpatient**

Rehabilitation Facility (CORF) services, you need to read Sections 8 and 9 of this chapter. Special rules apply to these types of care.

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

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

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

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

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

- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

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

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

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more that may benefit you **we can take up to 14 more calendar days**. If we take extra days,

we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a "fast complaint". (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

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

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

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

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

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

- **If you are asking for a standard appeal, submit your standard appeal in writing.** You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

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

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard" appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer

within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should **not** take extra days, you can file a "fast complaint." When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see **Section 11** of this chapter for information on complaints.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal where an independent review organization will review the appeal where the Office of Administrative Hearings will have a hearing on your case. Section 6.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we receive your appeal..
- **If our plan says no to part or all of your appeal, you have additional appeal rights. We will automatically send your request to a Level 2 appeal where the Office of Administrative Hearings will have a hearing on your case to see if they agree with our decision.**
- If we say no to part or all of what you asked for, we will send you a letter.

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

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

We will automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete. The Office of Administrative Hearings will schedule a hearing in your case and let you know of the date and time. You can ask to reschedule for a different day or time if needed.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 286 for information about continuing your benefits during Level 1 appeals.

Level 2 Appeals Process:

Step 1: We will send your case to the Office of Administrative Hearings. The Office of Administrative Hearings will have a hearing on your case.

- We will send the information about your appeal to this organization. This information is called your "case file" or "Evidence Packet." **We will send you a free copy of your Evidence Packet**.
- You have a right to give the Office of Administrative Hearings additional information to support your appeal.
- During your hearing, the Hearing Officer at the Office of Administrative Hearings will take a careful look at all of the information related to your appeal, and will hear from you and from staff from your plan about your request.

If you had a "fast" appeal at Level 1, you MAY also have a "fast" appeal at Level 2

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal. In some cases, even though you had a fast appeal for Level 1, you will not automatically receive a fast appeal at Level 2. You will get a fast appeal if using the standard deadlines could *cause serious harm to your health or hurt your ability to regain maximum function*.
- If your request is for a medical item or service and the Office of Administrative Hearings needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Office of

Administrative Hearings can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 60 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 Office of Administrative Hearings needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Office of Administrative Hearings can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

Step 2: The Office of Administrative Hearings gives you their answer.

The Office of Administrative Hearings will tell you its decision in writing and explain the reasons for it.

- **If the Office of Administrative Hearings says yes to part or all of your request,** we must authorize the medical care coverage **within 1 business day**.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.") In this case, the Office of Administrative Hearings will send you a letter:
  - Explaining its decision.
  - Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the Office of Administrative Hearings will tell you the dollar amount you must meet to continue the appeals process.
  - Telling you how to file a Level 3 appeal.

- If your Level 2 appeal is turned down 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 get after your Level 2 appeal.
  - The Level 3 appeal is handled by the Medicare Appeals Council. Section 10 in this chapter explains the process for Level 3, 4, and 5 appeals.

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

If the Office of Administrative Hearings decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Office of Administrative Hearings will describe this next appeal option.

See **Section 10** of this chapter for more information on your appeal rights after Level 2.

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

If you have already paid for a Medicaid service or item covered by the plan, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. When you send us a bill you have already paid, we will look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we will pay you back for the services or drugs.

Asking for reimbursement is asking for a coverage decision from us.

If you send us the paperwork that asks for reimbursement, you are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

If we say yes to your request: If the medical care you paid for is covered and you followed all the rules, we will send you the payment for the cost within 60 calendar days after we receive your request.

If we say no to your request: If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why.

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

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

We must give you our answer within 30 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you already received and paid for yourself, you are not allowed to ask for a fast appeal.

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

Section 6.6 External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only.**

You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- not medically necessary or
- experimental or investigational or
- not different from care you can get in the plan's network or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State. The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the state:

- You must file a Level 1 appeal with the plan and get the plan's Final Adverse Determination; **or**
- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); **or**
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; **or**
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the plan's Final Adverse Determination to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call your Care Team at 1-866-783-1444 (TTY: 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed.

Here are some ways to get an application:

- Call the Department of Financial Services, 1-800-400-8882
- Go to the Department of Financial Services' website at www.dfs.ny.gov.
- Contact the health plan at 1-866-783-1444 (TTY: 711).

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five work days) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York Medicaid by calling 1-866-712-7197.

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

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

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

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

Part D coverage decisions and appeals

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

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

- Asking to cover a Part D drug that is not on the plan's *List of Covered Drugs.* **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get). **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

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

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

Section 7.2 What is an exception?

Legal Terms
Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."** Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."** Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for a **"tiering exception."**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision.

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

1. **Covering a Part D drug for you that is not on our "Drug List".**
2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our "Drug List".

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our "Drug List" includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally **not** approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 Step-by-step: How to ask for a coverage decision, including an exception

Legal Term
A "fast coverage decision" is called an **"expedited coverage determination."**

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

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

If your health requires it, ask us to give you a fast coverage decision. *(*You cannot ask for a fast coverage decision to be paid back for a drug you have already bought.) **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a *drug you have not yet received*. (You cannot ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires**

that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Tells you how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: Request a "standard coverage decision" or a "fast coverage decision."

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

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

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

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.

  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

- We must give you our answer **within 14 calendar days** after we receive your request.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 7.5 Step-by-step: How to make a Level 1 appeal

Legal Term
An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."** A "fast appeal" is also called an **"expedited redetermination."**

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

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

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

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-866-783-1444.** Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website. Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

Deadlines for a "fast appeal"

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.

- If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a "standard" appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.6** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 30 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

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

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

Section 7.6 Step-by-step: How to make a Level 2 appeal

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

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

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

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding "at-risk" determination under our drug management program, we will automatically forward your claim to the IRE.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a**

copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

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

Deadlines for fast appeal

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

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called "upholding the decision" or "turning down your appeal.") In this case, the independent review organization will send you a letter:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

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

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you are being discharged too soon

When you are admitted to a hospital, you have the right to get all your covered hospital services that are necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."**
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

Section 8.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

Within two days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice.

If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call your Care Team or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does not mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call your Care Team 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 the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Section 8.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call your Care Team. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than midnight the day of your discharge.**
    - If you meet this deadline, you may stay in the hospital **after** your discharge date **without paying for it** while you wait to get the decision from the Quality Improvement Organization.
    - If you do **not** meet this deadline and you decide to stay in the hospital after your planned discharge date, **you may have to pay all of the costs** for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see **Section 8.4** of this chapter.

Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling your Care Team 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 www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeappealNotices.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the review organization says no, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage**

for your inpatient hospital services will end at noon on the day **after** the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has said *no* to your appeal, **and** you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 8.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

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

Section 8.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharged date

Legal Term
A fast review (or fast appeal) is also called an **"expedited appeal**."

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement 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

Step 1: Contact us and ask for a "fast review."

- **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 2 has contact information.

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 see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are 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 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 appeal, your case will automatically be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal Process

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

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

Step 1: 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. **Section 11** 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.

- 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 pay you back for our share of the costs of hospital care you 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 that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell you how to start 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 appeal.
- **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 9.1 This section is only about four services: Home health care, skilled nursing facility care, hospice 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*.)
- **Hospice care** you are getting as a patient in a hospice. (To learn about "hospice," 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 covered **home health services, skilled nursing care, hospice care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the four types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying** for your care.

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 9.2 We will tell you in advance when your coverage will be ending

Legal Term
"Notice of Medicare Non-Coverage." It tells you how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

1. **You receive a notice in writing** at least two days before our plan is going to stop covering your care. The notice tells you:
   - The date when we will stop covering the care for you.
   - How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.** Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan's decision to stop care.

Section 9.3 Step-by-step: How to make a Level 1 appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help at any time, call your Care Team. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a *fast-track appeal*. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.

- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see **Section 9.5** of this chapter.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

Legal Term
"Detailed Explanation of Non-Coverage". Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers told us of your appeal, you will get the **Detailed Explanation of Non-Coverage** from us that explains in detail our reasons for ending our coverage for your services.

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes?

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say no, then **your coverage will end on the date we have told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.

- If reviewers say no to your Level 1 appeal **and** you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 appeal.

Section 9.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, hospice care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

Step 1: Contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 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 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

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

Section 9.5 What if you miss the deadline for making your Level 1 appeal?

You can appeal to us instead

As explained above, 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

Legal Term
A fast review (or fast appeal) is also called an **"expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- **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 2 has contact information.

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.

Step 3: We give you our decision within 72 hours after you ask for a "fast review."

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer, and we 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 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, hospice 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.

Step 4: If we say no to your fast appeal, your case will automatically go on to the next level of the appeals process.

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

Step-by-Step: Level 2 Alternate appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **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.

Step 1: We 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. **Section 11** 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.

- 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 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 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 go on to a Level 3 appeal.

Step 3: If the independent review organization says no to 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- A Level 3 appeal is reviewed by an Administrative Law Judge or attorney adjudicator. **Section 10** of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Level 3 and beyond

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down. The letter you get from the Integrated Administrative Hearing Office (IAHO) will tell you what to do if you wish to continue the appeals process.

If you need assistance at any stage of the appeals process, you can contact the Independent Consumer Advocacy Network (ICAN). The phone number is 1-844-614-8800.

Level 3 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a

Level 3 decision that is favorable to you. We will decide whether to appeal this decision to Level 4.

- If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 4 appeal and how to continue with a Level 4 appeal.

Level 4 appeal A Judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you wish to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you

cannot appeal any further. The written response you receive to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 appeal **An Administrative Law Judge or attorney adjudicator who works for the Federal** government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process may or may not be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell

you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 appeal A judge at the **Federal District Court** will review your appeal.

- A judge will review all of the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with your Care Team? • Do you feel you are being encouraged to leave the plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by your Care Team or other staff at the plan? o Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 11.2 How to make a complaint

Legal Terms

- A **"Complaint"** is also called a **"grievance."**
- **"Making a complaint"** is also called **"filing a grievance".**
- **"Using the process for complaints"** is also called **"using the process for filing a grievance."**
- A **"fast complaint"** is also called an **"expedited grievance."**

Section 11.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling your Care Team is the first step.** If there is anything else you need to do, your Care Team will let you know.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- All complaints are investigated by VNS Health Total in order to understand and correct the problems that you identify.
    - We must notify you of our decision about your grievance as quickly as required based on your health status, but no later than 30 days after receiving your complaint.
    - We may extend the timeframe by up to 14 days if you request the extension or if we justify a need for additional information and the delay is in your best interest. If we must extend the deadline, we will notify you of this in writing.
    - If we deny your grievance in whole or in part, our written decision will explain why we denied it and will tell you about any dispute resolution options you may have.
- **Whether you call or write, you should contact your Care Team right away.** You can make the complaint at any time after you had the problem you want to complain about.

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a "fast complaint," it means we will give you **an answer within 24 hours**.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

Section 11.4 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about **quality of care**, you also have two extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 11.5 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about VNS Health Total directly to Medicare. To submit a complaint to Medicare, go to

www.medicare.gov/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048

You may also call New York Medicaid at 1-866-712-7197 (TTY:711).

CHAPTER 10:
Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in VNS Health Total may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and prescription drugs and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you may be able to end your membership in our plan or switch to a different plan one time during each of the following Special Enrollment Periods:

- January to March
- April to June
- July to September

If you joined our plan during one of these periods, you'll have to wait for the next period to end your membership or switch to a different plan. You can't use this Special Enrollment Period to end your membership in our plan between October and December. However, all people with Medicare can make changes from October 15 – December 7 during the Annual Enrollment Period. Section 2.2 tells you more about the Annual Enrollment Period.

- Choose any of the following types of Medicare plans:

- Another Medicare health plan, with or without prescription drug coverage
- Original Medicare *with* a separate Medicare prescription drug plan
- Original Medicare without a separate Medicare prescription drug plan
  - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in Chapter 2, Section 6 of this document).

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plans. Your enrollment in your new plan will also begin on this day.

Section 2.2 You can end your membership during the Annual Enrollment Period

You can end your membership during the Annual Enrollment Period (also known as the Annual Open Enrollment Period). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Annual Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage.
  - Original Medicare *with* a separate Medicare prescription drug plan

OR

  - Original Medicare *without* a separate Medicare prescription drug plan.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.

Note: If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Note: Section 2.1 tells you more about the special enrollment period for people with Medicaid.

- **The enrollment time periods vary** depending on your situation.
- **To find out if you are eligible for a Special Enrollment Period**, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:
- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan

OR

- Original Medicare *without* a separate Medicare prescription drug plan.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you receive "Extra Help" from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare

prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change your plan is received.

Note: Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call your Care Team.**
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan	• Enroll in the new Medicare health plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from VNS Health Total when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
Original Medicare *with* a separate Medicare prescription drug plan	• Enroll in the new Medicare prescription drug plan. Your new coverage will begin on the first day of the following month. • You will automatically be disenrolled from VNS Health Total when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan o If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment. o If you disenroll from Medicare prescription drug coverage and go 63 days or more in a row without creditable prescription drug coverage, you may have to pay a late enrollment penalty if you join a Medicare drug plan later.	• **Send us a written request to disenroll** Contact your Care Team if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from VNS Health Total when your coverage in Original Medicare begins.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your New York State Medicaid benefits, contact the New York Medicaid at 1-800-541-2831, TTY is 711. Ask how joining another plan or returning to Original Medicare affects how you get your New York State coverage.

SECTION 4 Until your membership ends, you must keep getting your medical, items services and drugs through our plan

Until your membership VNS Health Total ends, and your new Medicare and Medicaid coverage begins, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 VNS Health Total must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

VNS Health Total must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you are no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. If you no longer qualify for Medicaid, you will be required to disenroll from VNS Health Total.
- If you move out of our service area
- If you are away from our service area for more than six months
    - If you move or take a long trip, call your Care Team to find out if the place you are moving or traveling to is in our plan’s area.

- If you become incarcerated (go to prison)
- If you are no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance you have that provides prescription drug coverage
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you 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.
- If you do not receive at least one of the following services: nursing services in the home, therapies in the home, home health aide services, personal care services in the home, adult day health care, private duty nursing or Consumer-Directed Personal Assistance Services (CDPAS)
- If you require nursing home care, but are not institutionally eligible for Medicaid
- If you are no longer eligible for nursing home level of care. We will determine your nursing home eligibility every 6 months through an assessment conducted by a registered nurse in your home.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call your Care Team.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

VNS Health Total is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 11:
Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

If you have a disability and need help with access to care, please call your Care Team. If you have a complaint, such as a problem with wheelchair access, your Care Team can help.

VNS Health Health Plans complies with Federal civil rights laws. We do not exclude people or treat them differently because of race, religion, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression.

Our health plans provide the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:

  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call us at 1-866-783-1444. For TTY services, call 711.

If you believe that we have not given you these services or treated you differently because of race, religion, color, national origin, age, disability, sex, sexual orientation, gender identity, or gender expression you can file a grievance with us by:

Mail:	VNS Health Health Plan Compliance 220 East 42nd Street, New York, NY 10017
Telephone:	1-888-634-1558 (TTY: 711)
In person:	Call number above to schedule an appointment.
Fax:	646-459-7729
Email:	CivilRightsCoordinator@vnshealth.org
Web:	www.vnshealth.ethicspoint.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

- Web: Office for Civil Rights Complaint Portal at ocrportal.hhs.gov/ocr/portal/lobby.jsf
- Mail: U.S. Department of Health and Human Services
200 Independence Avenue SW., Room 509F,
HHH Building Washington, DC 20201
Complaint forms are available at
www.hhs.gov/ocr/office/file/index.html
- Telephone: 1-800-368-1019 (TTY/TDD 800-537-7697)

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, VNS Health Total, 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.

SECTION 4 Commitment to Compliance

At VNS Health, we know that Compliance is everyone's responsibility. This shared promise to meet our federal, state, and local requirements—in other words, our commitment to Compliance—has helped us remain one of the nation's leading health care organizations for nearly 125 years. Every day, we rededicate ourselves to doing the right thing—for our patients, clients, and plan members, for their families, for our VNS Health colleagues, and for our community.

If you have concerns that any member of the VNS Health team is not meeting our commitment to Compliance, please contact us.

Possible Compliance concerns might include:

- Bribes or exchanges for patient/member referrals or other business
- Questionable billing, coding or medical record documentation practices
- Poor quality of care
- Fraud, waste or abuse
- Any activity or business that could be interpreted as unethical or illegal

There are many ways that you can report a compliance concern:

	VNS Health	**VNS Health Health Plans**
Contact our Compliance Hotlines 24 hours a day, 7 days a week:	212-290-4773 (phone) 646-459-7729 (fax) **vnshealth.ethicspoint.com**	888-634-1558 (phone) 646-459-7730 (fax) **vnshealth.ethicspoint.com**
You can also reach us at:	**VNS Health Health Plans Compliance** 220 E. 42nd St, 6th Floor New York, NY 10017	**VNS Health Health Plans - Compliance** 220 E. 42nd St, New York, NY 10017 VNSHealthCompliance@vnshealth.org
You can also contact VNS Health Compliance Leadership directly at:	**VNS Health Chief Compliance & Privacy Officer** Annie Miyazaki-Grant Annie.Miyazaki@vnshealth.org	**VNS Health Health Plans Vice President Compliance & Regulatory Affairs** Doug Goggin-Callahan Douglas.Goggin-Callahan@vnshealth.org

CHAPTER 12:
Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of VNS Health Total, 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 have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

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.

Care Team (formally 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 the Care Team.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs.

Complaint — The formal name for making a complaint is filing a grievance. The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. 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.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 5 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 document.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered Services – The term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or **Disenrollment** – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

Dual Eligible Individual – A person who qualifies for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are: (1) provided by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Extra Help – A Medicare or a State 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.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage 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 $5,030.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period

that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, healthcare services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and healthcare status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Institutional Equivalent Special Needs Plan (SNP) –A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Integrated Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Integrated Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called “coverage decisions” in this document.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan.

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 covered Part A and Part B services. (**Note:** Because our members also get assistance from Medicaid, very few members ever reach this out-of-pocket maximum.)

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Open Enrollment Period – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare 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.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider –Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

Original Medicare (Traditional Medicare or Fee-for-service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers

payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

Palliative Care - Palliative Care works to improve quality of life for you and your family. You may receive care through the Palliative Care Program if you have a serious illness. Care is provided by a team of doctors, nurses, social workers, nutritionists and other specially trained people. Your team will be created for you and will work with you, your family and your doctors to help you live the best life possible.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you are first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late

enrollment penalty if you go 63 days or more in a row without Part D or other creditable prescription drug coverage.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization –Approval in advance to get services or certain drugs that may or may not be on our formulary. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics –Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Real Time Benefit Tool – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific

formulary and benefit information. This includes cost sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

CHAPTER 13:
Welcome to VNS Health Total Medicaid Advantage Plus

WELCOME TO VNS HEALTH TOTAL MEDICAID ADVANTAGE PLUS PROGRAM

Welcome to VNS Health Total Medicaid Advantage Plus (MAP) Program. The MAP Program is designed for people who have Medicare and Medicaid and who need health services and Community Based Long Term Services and Supports (CBLTSS) like home care and personal care to stay in their homes and communities as long as possible.

This handbook tells you about the added benefits VNS Health Total covers since you are enrolled in the VNS Health Total MAP Program. It also tells you how to request a service, file a complaint or disenroll from VNS Health Total MAP Program. The benefits described in this handbook are in addition to the Medicare benefits described in the VNS Health Total Medicare Evidence of Coverage. Keep this handbook with the VNS Health Total Medicare Evidence of Coverage. You need both to learn what services are covered, and how to get services.

HELP FROM MEMBER SERVICES (WHICH IS PART OF YOUR CARE TEAM)

You can call us at any time, 24 hours a day seven days a week, at the number below.

There is someone to help you at Member Services (which is part of your Care Team)
7 days a week, 8 am – 8 pm (Oct. – March), and
weekdays, 8 am – 8 pm (April – Sept.).
Call us toll free at 1-866-783-1444.
TTY users call 711

In addition, nurses are available 24 hours per day 365 day a year if you need help. You can reach them by dialing this same phone number.

Please call us if you need this document in other formats, such as large print, braille, or audio. You can get this information for free.

ELIGIBILITY FOR ENROLLMENT IN THE MAP PROGRAM

MAP is a program for people who have both Medicare and Medicaid. You are eligible to join the MAP Program if you meet all of the following requirements:

1) Are age **18** and older,
2) Reside in the plan's service area which is Albany, Bronx, Kings, Nassau, New York, Queens, Rensselaer, Richmond, Suffolk, Schenectady and Westchester counties of New York State,
3) Have Medicaid,
4) Have evidence of Medicare Part A & B coverage,
5) Are eligible for nursing home level of care (as of time of enrollment) using the Community Health Assessment (CHA),
6) Are capable at the time of enrollment of returning to or remaining in your home and community without jeopardy to your health and safety,
7) Are expected to require at least one of the following Community Based Long Term Services and Supports (CBLTSS) covered by the Medicaid Advantage Plus Plan for more than 120 days from the effective date of enrollment:
    a. Nursing services in the home
    b. Therapies in the home
    c. Home health aide services
    d. Personal care services in the home
    e. Adult day health care,
    f. Private duty nursing; or
    g. Consumer Directed Personal Assistance Services, ***and***
8) Must enroll in **VNS Health Total Medicare Advantage Dual Special Needs Plan**.

You must choose one of the doctors from the plan to be your Primary Care Provider (PCP). If you decide later to change your Medicare plan, you will also have to leave the VNS Health Total MAP Program.

The coverage explained in this Handbook becomes effective on the effective date of your enrollment in VNS Health Total MAP Program. Enrollment in the MAP Program is voluntary.

New York Independent Assessor Program (NYIAP) - Initial Assessment Process

The NYIAP will conduct an initial assessment for individuals who have

expressed an interest in enrolling in a Managed Long Term Care plan. The initial assessment process includes completing the:

- **Community Health Assessment (CHA):** The CHA is used to see if you need personal care and/or consumer directed personal assistance services (PCS/CDPAS) and are eligible for enrollment in a Managed Long Term Care (MLTC) plan.
- **Clinical appointment and Practitioner Order (PO):** The PO documents your clinical appointment and indicates that you:
    - have a need for help with daily activities, ***and***
    - that your medical condition is stable so that you may receive PCS and/or CDPAS in your home.

The NYIAP will schedule both the CHA and clinical appointment. The CHA will be completed by a trained registered nurse (RN). After the CHA, a clinician from the NYIAP will complete a clinical appointment and PO a few days later.

VNS Health Total will use the CHA and PO outcomes to see what kind of help you need and create your plan of care. If your plan of care proposes PCS and/or CDPAS for more than 12 hours per day on average, a separate review by the NYIAP Independent Review Panel (IRP) will be needed. The IRP is a panel of medical professionals that will review your CHA, PO, plan of care and any other necessary medical documentation. If more information is needed, someone on the panel may ask to examine you and/or discuss your needs with you. The IRP will make a recommendation to VNS Health Total about whether the plan of care meets your needs.

Once NYIAP has completed the initial assessment steps and determined that you are eligible for Medicaid Managed Long Term Care (MLTC), you can then choose which Managed Long Term Care plan in which to enroll. Because you also are enrolled in Medicare for this same plan, you have chosen to combine your benefits and enroll in VNS Health Total.

If you choose VNS Health Total as your plan, a Registered Nurse will do an assessment either virtually or by coming to your home in person, to determine the services that will be provided to you based on your needs. You will also be asked to sign an enrollment application and agreement. If you change your mind and choose not to enroll in the plan, you must withdraw your application before noon on the 20th of the month before your enrollment effective date. If the 20th falls on the weekend, the deadline would be before noon on the Friday immediately before that weekend.

In most cases, you will become a member of VNS Health Total on the first day of the month after you sign the enrollment application and agreement. We will confirm your actual enrollment date by telephone as soon as possible - usually a few days before your membership begins. Once you are a member, your Care Management Team will ensure that you get all the services that are outlined in your initial plan of care.

Your Care Team will provide you with other important documents, including your Provider and Pharmacy Directory and Formulary of prescription drugs. In addition, you will receive your Member ID Card by mail. Use this ID Card whenever you need services covered by VNS Health Total.

New York Medicaid Choice or the Local Department of Social Services must verify your Medicaid eligibility prior to enrollment in VNS Health Total.

In addition to the criteria listed at the beginning of this chapter, your enrollment in VNS Health Total would be denied in the following circumstances:

- You are currently receiving care in a hospital or residential facility operated by the State Office of Mental Health, the Office of Alcoholism and Substance Abuse Services or the Office for People with Developmental Disabilities (OPWDD).
- You are already enrolled in another Medicaid managed care program, a Home- and Community-based Services waiver program, a Day Treatment program sponsored by the Office for People with Developmental Disabilities. If you terminate your participation in these programs, you can then be considered for enrollment in VNS Health Total.
- You were *involuntarily* disenrolled from VNS Health in the past, and the situation that led to your disenrollment has not been resolved.
- You do not meet the eligibility criteria described on page 266.

Please be assured that VNS Health Total does not discriminate based on health status or change in health status and need for or cost of covered services.

Denial Enrollment Procedure: If VNS Health Total receives a denial notification from CMS, you would receive a denial notification from us within 10 calendar days. To match the denial, VNS Health Total would send a cancellation to the HRA (Human Resources Administration) with CMS proof of denial. If VNS Health Total receives notification of denial from LDSS (Local Departments of Social Services), we would then send a cancellation to CMS with notification from LDSS as proof.

Network providers will be paid in full directly by VNS Health Total for each service

authorized and provided to you with no co-pay or cost to you. If you receive a bill for covered services authorized by VNS Health Total you are not responsible to pay the bill. Please contact your Care Manager. You may be responsible for payment of covered services that were not authorized by VNS Health Total, or for covered services that are obtained by providers outside of the VNS Health Total network.

VNS Health Total will let you know when your PCP leaves the network and will help you choose another PCP so that you can keep getting covered services. If you are in the course of treatment for a specific illness or injury, please speak to your Care Team about transitional care. In some instances, you may be eligible for a 90-day transitional period to continue to receiving services from the physician who is leaving the VNS Health Total network until you complete your current course of treatment.

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan's network. If your network provider leaves the plan, you will have to switch to another provider who is part of our plan. As soon as we are notified that your PCP or other provider is no longer in the network, we will contact you to notify you of this change. If your PCP has left the network, you must choose another PCP. If you choose not to do so, a new PCP will be assigned to you. Your Care Team can assist you in selecting another PCP and in-network provider.

Plan Member (ID) Card

You will receive your VNS Health Total identification (ID) card within 10 business days of your effective enrollment date. Please verify that all information is correct on your card. Be sure to carry your identification card with you at all times along with your Medicaid card. If your card becomes lost or is stolen, please contact your Care Team at 1-866-783-1444 (TTY: 711).

SERVICES COVERED BY THE VNS HEALTH TOTAL PROGRAM

Deductibles and Copayments on Medicare Covered Services

Many of the services that you receive including inpatient and outpatient hospital services, doctor's visits, emergency services and laboratory tests are covered by Medicare and are described in the VNS Health Total Medicare Evidence of Coverage. Chapter 3 of the Medicare Evidence of Coverage explains the rules for using plan providers and getting care in a medical emergency or urgent care situations. Some services have deductibles and copayments. These amounts are shown in the Benefit Chart in Chapter 4 of the VNS Health Total Medicare Evidence of Coverage under the column "What you must pay when you get these covered services". Because you have joined VNS Health Total, and you have

Medicaid, VNS Health Total will pay these amounts. You do not have to pay these deductibles and co- payments except for those that apply to some pharmacy items.

If there is a monthly premium for benefits (see Chapter 1 of the VNS Health Total Medicare Evidence of Coverage) you will not have to pay that premium since you have Medicaid. We will also cover many services that are not covered by Medicare but are covered by Medicaid. The sections below explain what is covered.

Care Management Services
As a member of our plan, you will get Care Management Services. Our plan will provide you with a Care Manager who is a health care professional – usually a nurse or a social worker. Your Care Team will work with you and your doctor to decide the services you need and develop a care plan. Your Care Team will also arrange appointments for any services you need and arrange for transportation to those services. You may contact us with any questions, concerns, or if you need additional services, etc. Your Care Team is available by phone to help you manage your illnesses and other health needs. An RN, who is a member of your Care Team, will visit you periodically to perform an assessment of your health care needs and to work with you in developing a plan of care.

In addition, nurses are available 24 hours per day 365 day a year if you need help. Call us toll free at 1-866-783-1444 (TTY: 711).

Additional Covered Services
Because you have Medicaid and qualify for the MAP program, our plan will arrange and pay for the extra health and social services described below. You may get these services as long as they are medically necessary. Your Care Manager will help identify the services and providers you need. In some cases, you may need a referral or an order from your doctor to get these services. You must get these services from the providers who are in VNS Health Total network. If you cannot find a provider in our plan or have questions about how to get services when you need them, please contact your Care Team.

- **Outpatient Rehabilitation**
    - **Physical Therapy** – covers evaluation and treatment for injuries and diseases that change your ability to function, or to maintain current function or slow decline, when your doctor or other health care provider certifies your need for it. Prior authorization may be

required.

- **Occupational Therapy** – covers evaluation and treatment to help you perform activities of daily living (like dressing or bathing) to maintain current capabilities or slow decline when your doctor or other health care provider certifies you need it. Prior authorization may be required.
- **Speech Therapy** – covers evaluation and treatment to regain and strengthen speech and language skills, including cognitive and swallowing skills, or to maintain current function or slow decline, when your doctor or other health care provider certifies you need it. Prior authorization may be required.

- **Personal Care** (such as assistance with bathing, eating, dressing, toileting and walking) – VNS Health Total will coordinate the provision of personal care to help you with such activities as personal hygiene, dressing and eating, and home-environment support. Personal care must be medically necessary. Prior authorization is required.
- **Home Health Care Services Not Covered by Medicare** including nursing, home health aide, occupational, physical and speech therapies. VNS Health Total coordinates the provision of home care services including care from nurses, social workers, physical therapists, occupational therapists and speech therapists. These services are provided to help maintain, rehabilitate, guide and/or support your health. The staff provide these services based on a plan of care that your physician approves, and all services are provided in your home. Prior authorization is required.
- **Nutrition** – VNS Health Total can provide nutrition services from a registered dietitian who will assess your dietary needs and make recommendations to ensure that your diet is consistent with your health and personal needs. Prior authorization is required.
- **Medical Social Services** – Medically necessary assessment, arranging and providing aid for social problems related to maintaining an individual at home. Prior authorization is required.
- **Home Delivered Meals and/or meals in a group setting such as a day care –** VNS Health Total can provide you with home-delivered or congregate meals provided in accordance with your plan of care. Typically, one or two meals are provided per day for individuals who are unable to prepare meals and who do not have personal care services to assist with

meal preparation. Prior authorization is required.

- **Social Day Care** – Social day care is a structured program that provides you with socialization, personal care and nutrition in a protective setting. You may also receive services such as enhancement of daily living skills, transportation, and caregiver assistance. If interested, your Care Manager can arrange for you to attend a Social Day Care facility. Prior authorization is required.
- **Non-Emergency Transportation** – This service will be arranged by the New York State Department of Health Statewide Transportation Broker, known as Medical Answering Services (MAS). To arrange non-emergency medical transportation call 844-666-6270 (Downstate) or 866-932-7740 (Upstate), Monday – Friday, 7 am – 6 pm. If possible, you or your medical provider should contact MAS at least three days before your medical appointment and provide the details of your appointment (date, time, address, and name of provider) and your Medicaid identification number.

  To learn more about these services, visit Department of Health Transportation Webpage: www.health.ny.gov/health_care/medicaid/members/medtrans_overview.htm.

- **Private Duty Nursing** – Continuous skilled nursing care is provided in your home by licensed registered professional or licensed practical nurses. Prior authorization may be required.
- **Dental** – After you enroll in VNS Health Total, you will receive your dental care from the dental network for VNS Health Total. Your Member ID Card is accepted by hundreds of fully qualified dentists in Albany, Bronx, Kings, Nassau, New York, Queens, Rensselaer, Richmond, Schenectady, Suffolk, and Westchester counties. All dental services are provided through this network, and you can select any dentist listed in your Provider and Pharmacy Directory for your care. Your Care Manager or Care Team can help you with selecting a dentist or making an appointment, if you wish. As part of your dental benefit, you are entitled to twice yearly check-ups including x-rays and restorative services such as filings, crowns, root canals, extractions. If you need replacement dentures and implants, you will need a recommendation from your dentist to determine if it's medically necessary.
- **Social/Environmental Supports** (such as chore services, home modifications or respite) – In the event you require it, VNS Health Total

can provide you with social and environmental support services and items that support your medical needs and are included in your plan of care. These services and items include but are not limited to the following: home maintenance tasks, homemaker/chore services, pest control, housing modifications to improve your safety, and respite care. Prior authorization is required.

- **Personal Emergency Response System** – PERS is an electronic device that enables members to secure help in the event of an emergency (including a physical, emotional or environmental emergency). Such systems are usually connected to a member's phone and deliver a signal to a response center once a "help" button is activated. In the event of an emergency, the signal is received and appropriately acted on by our contracted response center. Prior authorization is required.
- **Adult Day Health Care** – VNS Health Total can arrange for you to receive Adult Day Health Care in a residential health care facility or state-approved site supervised by a physician. The services provided at Adult Day Health care include medical, nursing, food and nutrition, social services, rehabilitation therapy, leisure time activities, dental, pharmaceutical, and other services. You must not be homebound and must require certain preventive or therapeutic services to attend an Adult Day Health Care center. Prior authorization is required.
- **Nursing Home Care not covered by Medicare (provided you are eligible for institutional Medicaid)** – Although we do our best to meet your needs at home, there may be times when it is more appropriate for you to receive care in a nursing home. Admission to one of our participating nursing homes is made on an individual basis. The decision to receive care in a nursing home must be made by you, your doctor, your family, and your Care Manager. There are two types of nursing home stays. They are short-term or rehabilitation stays following hospitalization and long-term stays for ongoing care. No prior hospital stay is required.
- **Inpatient Mental Health Care Over the 190-day Lifetime Medicare Limit** – VNS Health Total includes mental health care services that require a hospital stay. Medicaid covers the deductible and cost of the days in excess of the Medicare 190-day lifetime limit. There is no limit to the number of days covered by the plan each hospital stay. You are covered for up to 365 days per year (366 in a leap year) with no deductible or copayment.

- **Audiology** – Medicare and Medicaid hearing services and products when medically necessary to alleviate disability caused by the loss or impairment of hearing. Services include hearing aid selecting, fitting, and dispensing; hearing aid checks following dispensing, conformity evaluations and hearing aid repairs; audiology services including examinations and testing, hearing aid evaluations and hearing aid prescriptions; and hearing aid products including hearing aids, earmolds, special fittings and replacement parts. No prior authorization required.
- **Durable Medical Equipment –** Medicare and Medicaid covered durable medical equipment, including devices and equipment other than prosthetic or orthotic appliances having the following characteristics: can withstand repeated use for a protracted period of time; are primarily and customarily used for medical purposes; are generally not useful to a person in the absence of illness or injury and are usually fitted, designed or fashioned for a particular individual's use. Must be ordered by a qualified practitioner. No homebound prerequisite and including non-Medicare DME covered by Medicaid (e.g. tub stool; grab bars). Medical/Surgical supplies, enteral/parenteral formulas and supplements, and hearing aid batteries. Requires prior authorization.
- **Medical Supplies** – items for medical use other than drugs, prosthetic or orthotic appliances, durable medical equipment, or orthopedic footwear which have been ordered by a practitioner in the treatment of a specific medical condition and which are usually: consumable, non-reusable, disposable, for a specific rather than incidental purpose, and generally have no salvageable value. Prior authorization is required.
- **Prosthetics and Orthotics** – Medicare and Medicaid covered prosthetics, orthotics and orthopedic footwear. No diabetic prerequisite for orthotics.
- **Optometry –** Medicare and Medicaid covered vision services including optometry.
- **Consumer Directed Personal Assistance Services** (CDPAS) is a self-directed home care model available to Medicaid eligible consumers who are chronically ill or physically disabled and in need of home care services. Consumers who are in need of personal care, home health aide and/or or skilled nursing services may receive these services from a consumer directed personal care assistant under the direction of the enrollee or enrollee’s designated representative. Your Care Manager can help determine the level of assistance with personal care services, home health aide services and/or skilled nursing services you are eligible to receive. To

find out more about CDPAS and determine if it is right for you, please speak with you Care Manager. Prior authorization is required.

Covered Behavioral Health (Mental Health and Addiction) Services

Adult Outpatient Mental Health Care

- **Continuing Day Treatment (CDT):** Provides seriously mentally ill adults with the skills and supports necessary to remain in the community and be more independent. You can attend several days per week with visits lasting more than an hour.
- **Partial Hospitalization (PH):** A program which provides mental health treatment designed to stabilize or help acute symptoms in a person who may need hospitalization.

Adult Outpatient Rehabilitation Mental Health Care

- **Assertive Community Treatment (ACT):** ACT is a team approach to treatment, support, and rehabilitation services. Many services are provided by ACT staff in the community or where you live. ACT is for individuals that have been diagnosed with serious mental illness or emotional problems.
- **Mental Health Outpatient Treatment and Rehabilitative Services (MHOTRS):** A program that provides treatment, assessment, and symptom management. Services may include individual and group therapies at a clinic location in your community.
- **Personalized Recovery Oriented Services (PROS):** A complete recovery-oriented program if you have severe and ongoing mental illness. The goal of the program is to combine treatment, support, and therapy to aid in your recovery.

Adult Outpatient Rehabilitative Mental Health and Addiction Services for Members Who Meet Clinical Requirements. These are also known as CORE.

Community Oriented Recovery and Empowerment (CORE) Services: Person-centered, recovery program with mobile behavioral health supports to help build skills and promote community participation and independence. CORE Services are available for members who have been identified by the State as meeting the high need behavioral health risk criteria. Anyone can refer someone, or self-refer, to CORE Services.

- **Psychosocial Rehabilitation (PSR):** This service helps with life skills, like making social connections; finding or keeping a job; starting or

returning to school; and using community resources.

- **Community Psychiatric Supports and Treatment (CPST)**: This service helps you manage symptoms through counseling and clinical treatment.
- **Empowerment Services – Peer Supports:** This service connects you to peer specialists who have gone through recovery. You will get support and assistance with learning how to:
    - Live with health challenges and be independent.
    - Help you make decisions about your own recovery, and
    - Find natural supports and resources.
- **Family Support and Training (FST):** This service gives your family and friends the information and skills to help and support you.

Adult Mental Health Crisis Services

- **Comprehensive Psychiatric Emergency Program (CPEP):** A hospital-based program which provides crisis supports and beds for extended observation (up to 72 hours) to individuals who need emergency mental health services.
- **Mobile Crisis and Telephonic Crisis Services:** An in-community service that responds to individuals experiencing a mental health and/or addiction crisis.
- **Crisis Residential Programs:** A short term residence that provides 24 hours per day services for up to 28 days, for individuals experiencing mental health symptoms or challenges in daily life that makes symptoms worse. Services can help avoid a hospital stay and support the return to your community.

Adult Outpatient Addiction Services

- **Opioid Treatment Centers (OTP):** are Office of Addiction Services and Supports certified sites where medication to treat opioid dependency is given. These medications can include methadone, buprenorphine, and suboxone. These facilities also offer counseling and educational services. In many cases, you can get ongoing services at an OTP clinic over your lifetime.

Adult Residential Addiction Services

- **Residential Services** are for people who are in need of 24-hour support in their recovery in a residential setting. Residential services help maintain recovery through a structured, substance-free setting. You can get group support and learn skills to aid in your recovery.

Adult Inpatient Addiction Rehabilitation Services

- **State Operated Addiction Treatment Center's (ATC):** provide care that is responsive to your needs and supports long-term recovery. Staff at each facility are trained to help with multiple conditions, such as mental illness. They also support aftercare planning. Types of addiction treatment services are different at each facility but can include medication-assisted treatment; problem gambling, gender-specific treatment for men or women, and more.
- **Inpatient Addiction Rehabilitation:** programs can provide you with safe setting for the evaluation, treatment, and rehabilitation of substance use disorders. These facilities offer 24-hour, 7-day a-week care that is supervised at all times by medical staff. Inpatient services include management of symptoms related to addiction and monitoring of the physical and mental complications resulting from substance use.
- **Inpatient Medically Supervised Detox** programs offer inpatient treatment for moderate withdrawal and include supervision under the care of a physician. Some of the services you can receive are a medical assessment within twenty-four (24) hours of admission and medical supervision of intoxication and withdrawal conditions.

Limitations

- Nursing Home Care is covered for individuals who are considered to be permanently placed in a nursing home, provided you are eligible for institutional Medicaid coverage.
- Enteral formula and nutritional supplements are limited to individuals who cannot obtain nutrition through any other means, and to the following conditions:

1) tube-fed individuals who cannot chew or swallow food and must obtain nutrition through formula via tube; ***and***
2) individuals with rare inborn metabolic disorders requiring specific medical formulas to provide essential nutrients not available through any other means.

Under certain conditions, adults who have HIV, AIDS, or HIV-related illness, or other disease or condition, may be eligible for additional oral nutrition.

Coverage of certain inherited disease of amino acid and organic acid metabolism shall include modified solid food products that are low-protein or which contain modified protein.

Telehealth

You can receive some services through telehealth when appropriate. It is your choice if you receive services in person or through telehealth. If you have additional questions on telehealth, please contact your Care Manager.

Getting Care Outside the Service Area

You must inform your Care Manager when you travel outside your coverage area. Should you find yourself in need of services outside your coverage area, your Care Manager should be contacted to assist you in arranging services.

Emergency Service

Emergency Service means a sudden onset of a condition that poses a serious threat to your health. For medical emergencies please dial 911. As noted above, prior authorization is not needed for emergency service. However, you should notify VNS Health Total within 24 hours of the emergency. You may be in need of long-term care services that can only be provided through VNS Health Total.

If you are hospitalized, a family member or other caregiver should contact VNS Heath Total's Care Team within 24 hours of admission. Your Care Manager will suspend your home care services and cancel other appointments, as necessary. Please be sure to notify your primary care physician or hospital discharge planner to contact VNS Health Total so that we may work with them to plan your care upon discharge from the hospital.

Transitional Care Procedures

New enrollees in VNS Health Total may continue an ongoing course of treatment for a transitional period of up to 60 days from enrollment with a non-network health care provider if the provider accepts payment at the plan rate, adheres to VNS Health Total quality assurance and other policies, and provides medical information about the care to the plan.

If your provider leaves the network, an ongoing course of treatment may be continued for a transitional period of up to 90 days if the provider accepts payment at the plan rate, adheres to plan quality assurance and other policies, and provides medical information about the care to the plan.

Money Follows the Person (MFP)/Open Doors

This section explains the services and supports that are available through Money Follows the Person (MFP)/Open Doors. MFP/Open Doors is a program that can help you move from a nursing home back into your home or residence in the

community. You may qualify for MFP/Open Doors if you:

- Have lived in a nursing home for three months or longer and
- Have health needs that can be met through services in their community

MFP/Open Doors has people, called Transition Specialists and Peers, who can meet with you in the nursing home and talk with you about moving back to the community. Transition Specialists and Peers are different from Care Managers and Discharge Planners. They can help you by:

- Giving you information about services and supports in the community
- Finding services offered in the community to help you be independent
- Visiting or calling you after you move to make sure that you have what you need at home

For more information about MFP/Open Doors, or to set up a visit from a Transition Specialist or Peer, please call the New York Association on Independent Living at 1-844-545-7108, or email mfp@health.ny.gov. You can also visit MFP/Open Doors on the web at www.health.ny.gov/mfp or www.ilny.org.

MEDICAID SERVICES NOT COVERED BY OUR PLAN

There are some Medicaid services that VNS Health Total does not cover but may be covered by regular Medicaid. You can get these services from any provider who takes Medicaid by using your Medicaid Benefit Card. Call your Care Team at 1-866-783-1444 (TTY: 711) if you have a question about whether a benefit is covered by VNS Health Total or Medicaid. Some of the services covered by Medicaid using your Medicaid Benefit Card include:

Pharmacy
Most prescription drugs are covered by VNS Health Total Medicare Part D as described in section 6 of the VNS Health Total Medicare Evidence of Coverage (EOC). Regular Medicaid will cover some drugs not covered by VNS Health Total Medicare Part D. Medicaid may also cover drugs that we deny.

Certain Mental Health Services, including:

- Health Home (HH) and Health Home Plus (HH+) Care Management services
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs
- OMH Day Treatment

- OASAS Residential Rehabilitation for Youth
- Certified Community Behavioral Health Clinics (CCBHC)
- OMH Residential Treatment Facility (RTF)

For MAP enrollees up to the age of 21:

- Children and Family Treatment and Support Services (CFTSS)
- Children's Home and Community Based Services (HCBS)

Certain Intellectual Disability and Developmental Disabilities Services, including:

- Long-term therapies
- Day Treatment
- Medicaid Service Coordination
- Services received under the Home and Community Based Services Waiver

Other Medicaid Services

- Directly Observed Therapy for TB (Tuberculosis)
- HIV COBRA Case Management
- Medically necessary ovulation enhancing drugs and medical services related to prescribing and monitoring the use of such drugs, for members meeting criteria

Family Planning

- Members may go to any Medicaid doctor or clinic that provides family planning care. You do not need a referral from your Primary Care Provider (PCP).

SERVICES NOT COVERED BY VNS HEALTH TOTAL OR MEDICAID

You must pay for services that are not covered by VNS Health Total or by Medicaid if your provider tells you in advance that these services are not covered, AND you agree to pay for them. Examples of services not covered by VNS Health Total or Medicaid are:

- Cosmetic surgery if not medically needed
- Personal and Comfort items
- Services of a provider that is not part of the plan outside of a medical emergency (unless VNS Health Total authorizes you to see that provider)

If you have any questions, call your Care Team at 1-866-783-1444 (TTY: 711).

SERVICE AUTHORIZATION, APPEALS AND COMPLAINTS PROCESSES

You have Medicare and also get assistance from Medicaid. Information in this section covers your rights for all of your Medicare and most of your Medicaid benefits. In most cases, you will use one process for your Medicare benefits and a different process for your Medicaid benefits. This is sometimes called an "integrated process" because it integrates Medicare and Medicaid processes.

However, for some of your Medicaid benefits, you may also have the right to an additional External Appeals process. See page 291 for more information on the External Appeals process.

Section 1: Service Authorization Request (also known as Coverage Decision Request)

Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

When you ask for approval of a treatment or service, it is called a **service authorization request (also known as a coverage decision request)**. To get a service authorization request, you must

You or your provider may call your Care Team toll-free at 1-866-783-1444 (TTY: 711) or send your request in writing to:

VNS Health Total
Health Plans - Medical Management Department
220 East 42nd Street
New York, NY 10017

We will authorize services in a certain amount and for a specific period of time. This is called an **authorization period**.

Prior Authorization

Some covered services require **prior authorization** (approval in advance) from the VNS Health Total Medical Management Department before you get them. You or someone you trust can ask for prior authorization.

Requests for new or additional covered services may be obtained through your Care Team by you, your designated representative, or your provider. Requests can be made verbally or in writing. Your Care Team will assist you in obtaining authorization for covered services requiring prior authorization. The following treatments and services must be approved **before** you get them:

- Personal Care Services
- Home Health Care
- Adult Day Health Care Services
- Chore or Housekeeping Services
- Consumer Directed Personal Assistance Services
- Environmental Modifications
- Home Delivered Meals
- Home Safety Modifications
- Medical Equipment
- Medical and Surgical Supplies
- Nursing Home Care
- Medical Social Services
- Nutrition Services
- Personal Emergency Response System (PERS)
- Private Duty Nursing
- Social Day Care Service

Concurrent Review
You can also ask the VNS Health Medical Management Department to get more of a service than you are getting now. This is called **concurrent review**.

Retrospective Review
Sometimes we will do a review on the care you are getting to see if you still need the care. We may also review other treatments and services you already got. This is called **retrospective review**. We will tell you if we do these reviews.

What happens after we get your service authorization request
The health plan has a review team to be sure you get the services you qualify for. Doctors and nurses are on the review team. Their job is to be sure the treatment or services you asked for are medically needed and right for you. They do this by checking your treatment plan against acceptable medical standards.

We may decide to deny a service authorization request or to approve it for an amount that is less than you asked for. A qualified health care professional will make these decisions. If we decide that the service you asked for is not medically necessary, a clinical peer reviewer will make the decision. A clinical peer reviewer may be a doctor, a nurse, or a health care professional who typically provides the care you asked for. You can ask for the specific medical standards, called **clinical review criteria**, used to make the decision about medical necessity.

After we get your request, we will review it under either a **standard** or a **fast-track** process. You or your provider can ask for a fast-track review if you or your provider believes that a delay will cause serious harm to your health. If we deny your request for a fast-track review, we will tell you and handle your request under the standard review process. In all cases, we will review your request as fast as your medical condition requires us to do so, but no later than mentioned below. More information on the fast- track process is below.

We will tell you and your provider both by phone and in writing if we approve or deny your request. We will also tell you the reason for the decision. We will explain what options you have if you don't agree with our decision.

Standard Process
Generally, we use the **standard timeframe** for giving you our decision about your request for a medical item, treatment, or service unless we have agreed to use the fast-track deadlines.

- A standard review for a prior authorization request means we will give you an answer within 3 workdays of when we have all the information we need, but no later than **14 calendar days** after we get your request. If your case is a **concurrent review** where you are asking for a change to a service you are already getting, we will make a decision within 1 workday of when we have all the information we need but will give you an answer no later than 14 calendar days after we get your request.
- **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 what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If you believe we should **not** take extra days, you can file a **fast complaint.**

When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for service authorizations and appeals. For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan.)

If we do not give you our answer within 14 calendar days (or by the end of the extra days if we take them), you can file an appeal.

- **If our answer is yes to part or all of what you asked for**, we will authorize the service or give you the item that you asked for.
- **If our answer is no to part or all of what you asked for,** we will send you a written notice that explains why we said no. Section 2: Level 1 Appeals (also known as Level 1) later in this chapter tells how to make an appeal.

Fast Track Process

If your health requires it, ask us to give you a **fast service authorization.**

- A fast review of a prior authorization request means we will give you an answer within 1 workday of when we have all the information we need but no later than **72 hours** from when you made your request to us**.**
- 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 what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
- If you believe we should not take extra days, **you can file a fast complaint** (For more information about the process for making complaints, including fast complaints, see Section 5: What To Do If You Have A Complaint About Our Plan, below, for more information.) We will call you as soon as we make the decision.
- 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) you can file an appeal.

See Section 2: Level 1 Appeals, below for how to make an appeal.

To get a fast service authorization, you must meet two requirements:

1. You are asking for coverage for medical care you have not gotten yet. (You cannot get a fast service authorization if your request is about payment for medical care, you already got.)
2. Using the standard deadlines could cause serious harm to your life or health or hurt your ability to function.

If your provider tells us that your health requires a fast service authorization, we will automatically agree to give you a fast service authorization.

If you ask for a fast service authorization on your own, without your provider's support, we will decide whether your health requires that we give you a fast service authorization.

If we decide that your medical condition does not meet the requirements for a fast service authorization, 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 provider asks for the fast service authorization, we will automatically give a fast service authorization.
- The letter will also tell how you can file a "fast complaint" about our decision to give you a standard service authorization instead of the fast service authorization you asked for. (For more information about the process for making complaints, including fast complaints, see "**Section 5: What To Do If You Have A Complaint About Our Plan"** later in this chapter.)

If our answer is yes to part or all of what you asked for, we must give you our answer within 72 hours after we got your request. If we extended the time needed to make our service authorization on your request for a medical item or service, we will give you our answer by the end of that extended period.

If our answer is no to part or all of what you asked for, we will send you a detailed written explanation as to why we said no. If you are not satisfied with our answer, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If you do not hear from us on time, it is the same as if we denied your service authorization request. If this happens, you have the right to file an appeal with us. See Section 2: Level 1 Appeals, below for more information.

If we are changing a service you are already getting:

- In most cases, if we make a decision to reduce, suspend or stop a service we have already approved that you are now getting, we must tell you at least 15 days before we change the service.
- If we are reviewing care that you got in the past, we will make a decision about paying for it within 30 days of getting necessary information for the retrospective review. If we deny payment for a service, we will send a notice to you and your provider the day we deny the payment. **You will not have to pay for any care you got that the plan or Medicaid covered even if we later deny payment to the provider.**

You may also have special **Medicare rights if your coverage for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF)** services is ending. For more information about these rights, refer to **Chapter 9** of the VNS Health Total Evidence of Coverage.

What To Do If You Want To Appeal A Decision About Your Care
If we say no to your request for coverage for a medical item or service, you decide if you want to make an appeal.

- If we say no, you have the right to make an appeal and ask us to reconsider this decision. Making an appeal means trying again 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 below).
- VNS Health Total can also explain the complaints and appeals processes available to you depending on your complaint. You can call your Care Team at 1-866-783-1444 (TTY: 711) to get more information on your rights and the options available to you.

At any time in the process, you, or someone you trust can also file a complaint about the review time with the New York Medicaid by calling 1-866-712-7197.

<u>Section 2: Level 1 Appeals (also known as a Plan Level Appeal)</u>
Information in this section applies to all of your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

There are some treatments and services that you need approval for before you get

them or to be able to keep getting them. This is called prior authorization. Asking for approval of a treatment or service is called a service authorization request. We describe this process earlier in Section 1of this chapter. If we decide to deny a service authorization request or to approve it for an amount that is less than asked for, you will receive a notice called an Integrated Coverage Determination Notice. If you receive an Integrated Coverage Determination Notice and disagree with our decision, you have the right to make an appeal. Making an appeal means trying to get the medical item or service you want by asking us to review your request again.

You can file a Level 1 Appeal:
When you appeal a decision for the first time, this is called a Level 1 Appeal, or a Plan Appeal. In this appeal, we review the decision we made to see if we properly followed all the rules. Different reviewers handle your appeal than the ones who made the original unfavorable decision. When we complete the review, we will give you our decision. Under certain circumstances, which we discuss below, you can request a fast appeal.

Steps to file a Level 1 Appeal:

- If you are not satisfied with our decision, you have **60 days** from the date on the Integrated Coverage Determination Notice to file an appeal. If you miss this deadline and have a good reason for missing it, we may give you more time to file your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that kept you from contacting us or if we gave you incorrect or incomplete information about the deadline for asking for an appeal.
- If you are appealing a decision, we made about coverage for care you have not gotten yet, you and/or your provider will need to decide if you need a **"fast appeal."**
    - The requirements and procedures for getting a fast appeal are the same as for getting a "fast track service authorization." To ask for a fast appeal, follow the instructions for asking for a fast track service authorization. (These instructions are given in Section 1, in the Fast Track Process section.)
    - If your provider tells us that your health requires a "fast appeal," we will give you a fast appeal.
    - If your case was a **concurrent review** where we were reviewing a service you are already getting, you will automatically get a fast appeal.

- You can file an appeal yourself or ask someone you trust to file the Level 1 Appeal for you. You can call us at 1-866-783-1444 (TTY: 711) if you need help filing a Level 1 Appeal.
  - Only someone you name in writing can represent you during your appeal. If you want a friend, relative, or other person to be your representative during your appeal, you can complete the Appeal Request Form that was attached to the Integrated Coverage Determination Notice, complete an Appointment of Representative form, or write and sign a letter naming your representative.
    - To get an "Appointment of Representative" form, call us and ask for the form. You can also get the form on the Medicare website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at vnshealthplans.org. The form gives the person permission to act for you. You must give us a copy of the signed form, ***or***
    - You can write a letter and send it to us. (You or the person named in the letter as your representative can send us the letter.)
- We will not treat you any differently or act badly toward you because you file a Level 1 Appeal.
- You can make the Level 1 Appeal by phone or in writing. After your call, we will send you a form that summarizes your phone appeal. You can make any needed changes to the summary before signing and returning the form to us.

Continuing Your Service or Item While Appealing a Decision About Your Care

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

- If we decided to change or stop coverage for a service or item that you currently get, we will send you a notice before taking action.
- If you disagree with the action, you can file a Level 1 Appeal.
- We will continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on the Integrated Coverage Determination Notice or by the intended effective date of the action,

whichever is later.

- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 Appeal is pending. You will also keep getting all other services or items (that are not the subject of your appeal) with no changes.
- ***Note:*** If your provider is asking that we continue a service or item you are already getting during your appeal, you may need to name your provider as your representative.

What happens after we get your Level 1 Appeal

- Within 15 days, we will send you a letter to let you know we are working on your Level 1 Appeal. We will let you know if we need additional information to make our decision.
- We will send you a copy of your case file, free of charge, which includes a copy of the medical records and any other information and records we will use to make the appeal decision. If your Level 1 Appeal is fast tracked, there may be a short time to review this information.
- Qualified health professionals who did not make the first decision will decide appeals of clinical matters. At least one will be a clinical peer reviewer.
- Non-clinical decisions will be handled by persons who work at a higher level than the people who worked on your first decision.
- You can also provide information to be used in making the decision in person or in writing. Call us at 1-866-783-1444 (TTY: 711) if you are not sure what information to give us.
- We will give you the reasons for our decision and our clinical rationale, if it applies. If we deny your request or approve it for an amount that is less than you asked for, we will send you a notice called an Appeal Decision Notice. If we say no to your Level 1 Appeal, we will automatically send your case on to the next level of the appeals process.

Timeframes for a Standard Appeal

- If we are using the standard appeal timeframes, we must give you our answer on a request **within 30 calendar days** after we get your appeal if your appeal is about coverage for services, you have not gotten yet.
- 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 we decide we need to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.
  - 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 5: What to Do If You Have A Complaint About Our Plan, below, for more information.
- If we do not give you an answer by the applicable deadline above (or by the end of the extra days we took on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process.
  - An independent outside organization will review it.
  - We talk about this review organization and explain what happens at Level 2 of the appeals process in Section 3: Level 2 Appeals.
- **If our answer is "Yes" to part or all of what you asked for,** we must authorize or provide the coverage we have agreed to provide within 72 hours of when we make our decision.
- **If our answer is no to part or all of what you asked for**, to make sure we followed all the rules when we said no to your appeal, **we are required to send your appeal to the next level of appeal.** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Timeframes for a Fast Appeal

- When we are using the fast timeframes, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires us to do so.
- 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 we

decide to take extra days to make the decision, we will tell you in writing what information is needed and why the delay is in your best interest. We will make a decision as quickly as we can when we receive the necessary information, but no later than 14 days from the day we asked for more information.

- If we do not give you an answer within 72 hours (or by the end of the extra days we took), we are required to automatically send your request on to Level 2 of the appeals process which is discussed below in Section 3: Level 2 Appeals.

If our answer is "YES" to part or all of what you asked for, we must authorize or provide the coverage we have agreed to provide within 72 hours after we get your appeal.

If our answer is "NO" to part or all of what you asked for, we will automatically send your appeal to an independent review organization for a Level 2 Appeal. You or someone you trust can also file a complaint with the plan if you don't agree with our decision to take more time to review your action appeal.

- During the Level 2 Appeal, an independent review organization, called the **Administrative Hearing Office or Hearing Office,** reviews our decision on your first appeal. This organization decides whether the decision we made should be changed.
- We tell you about this organization and explain what happens at Level 2 of the appeals process later in Section 3: Level 2 Appeals.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York Medicaid by calling 1-866-712-7197.

Section 3: Level 2 Appeals

Information in this section applies to **all** your Medicare and most of your Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

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 **Hearing Office** reviews our decision for your Level 1 appeal. This organization decides whether the decision we made should be changed.

- **The Hearing Office is an independent New York State agency**. It is not connected with us. Medicare and Medicaid oversee 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 free copy of your case file**.
- You have a right to give the Hearing Office additional information to support your appeal.
- Reviewers at the Hearing Office will take a careful look at all the information related to your appeal. The Hearing Office will contact you to schedule a hearing.
- If you had a fast appeal to our plan at Level 1 because your health could be seriously harmed by waiting for a decision under a standard timeframe, you will automatically get 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 gets your appeal.
- If the Hearing Office needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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 would automatically get a standard appeal at Level 2.
- The review organization must give you an answer to your Level 2 Appeal **within 60 calendar days** of when it gets your appeal. There is a total of 90 days available between the date you request a plan appeal (Level 1) and the date that the Hearing Office decides your Level 2 appeal.
- If the Hearing Office needs to gather more information that may benefit you, it can take up to 14 more calendar days.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal will also continue during Level 2. Go to page 287 for information about continuing your benefits during Level 1 Appeals.

The Hearing Office will tell you about its decision in writing and explain the reasons for it.

- If the Hearing Office says **"Yes"** to part or all your request, we must authorize the service or give you the item **within one business day of when we get the Hearing Office's decision**.

- If the Hearing Office says **"No"** to part or all of your appeal, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision" or "turning down your appeal.")

If the Hearing Office says "No" to part or all your appeal, you can choose whether you want to take your appeal further.

- There are two additional levels in the appeals process after Level 2 (for a total of four levels of appeal).
- If your Level 2 Appeal is turned down, you must decide whether you want to go on to Level 3 and make a third appeal. The written notice you got after your Level 2 Appeal has the details on how to do this.
- The Medicare Appeals Council handles the Level 3 Appeal. After that, you may have the right to ask a federal court to look at your appeal.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York Department of Health by calling 1-866-712-7197.

Section 4: External Appeals for Medicaid Only

You or your doctor can ask for an External Appeal for **Medicaid covered benefits only**. You can ask New York State for an independent **external appeal** if our plan decides to deny coverage for a medical service you and your doctor asked for because it is:

- not medically necessary or
- experimental or investigational or
- not different from care you can get in the plan's network or
- available from a participating provider who has correct training and experience to meet your needs.

This is called an External Appeal because reviewers who do not work for the health plan or the state make the decision. These reviewers are qualified people approved by New York State (the State). The service must be in the plan's benefit package or be an experimental treatment. You do not have to pay for an external appeal.

Before you appeal to the State:

- You must file a Level 1 appeal with the plan and get the Plan's Appeal Decision Notice; ***or***

- You may ask for an expedited External Appeal at the same time if you have not gotten the service and you ask for a fast appeal. (Your doctor will have to say an expedited Appeal is necessary); ***or***
- You and the plan may agree to skip the plan's appeals process and go directly to External Appeal; ***or***
- You can prove the plan did not follow the rules correctly when processing your Level 1 appeal.

You have **4 months** after you get the Plan's Appeal Decision Notice to ask for an External Appeal. If you and the plan agreed to skip the plan's appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement.

To ask for an External Appeal, fill out an application and send it to the Department of Financial Services.

- You can call Member Services (which is part of your Care Team) at 1-866-783-1444 (TTY: 711) if you need help filing an appeal.
- You and your doctors will have to give information about your medical problem.
- The External Appeal application says what information will be needed. Here are some ways to get an application:
  - Call the Department of Financial Services, 1-800-400-8882
  - Go to the Department of Financial Services' website at www.dfs.ny.gov.
  - Contact the health plan at 1-866-783-1444 (TTY: 711)

The reviewer will decide your External Appeal in 30 days. If the External Appeal reviewer asks for more information, more time (up to five workdays) may be needed. The reviewer will tell you and the plan the final decision within two days after making the decision.

You can get a faster decision if your doctor says that a delay will cause serious harm to your health. This is called an **expedited External Appeal**. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. The reviewer will tell you and the plan the decision right away by phone or fax. Later, the reviewer will send a letter that tells you the decision.

At any time in the process, you or someone you trust can also file a complaint about the review time with the New York State Department of

Health by calling 1- 866-712-7197.

Section 5: What To Do If You Have A Complaint About Our Plan

Information in this section applies to **all** of your Medicare and Medicaid benefits. This information does not apply to your Medicare Part D prescription drug benefits.

We hope our plan serves you well. If you have a problem with the care or treatment you get from our staff or providers or if you do not like the quality of care or services you get from us, call your Care Team at 1-866-783-1444 (TTY: 711) or write to your Care Team. **The formal name for making a complaint is filing a grievance.**

You can ask someone you trust to file the complaint for you. If you need our help because of a hearing or vision impairment or if you need translation services, we can help you. We will not make things hard for you or take any action against you for filing a complaint.

How to File a Complaint:

- **Usually, calling your Care Team is the first step.** If there is anything else you need to do, your Care Team will let you know. 1-866-783-1444 (TTY: 711).
- 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.
- Please include the description of your complaint, the date of the incident, and any provider information, if applicable.
- **Whether you call or write, you should contact your Care Team right away.** You can make the complaint at any time after you had the problem you want to complain about.

What happens next?

- **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.
- **We answer complaints within 30 calendar days.**
- If you are making a complaint because we denied your request for a fast service authorization or a fast appeal, **we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you

an answer within 24 hours.

- If we 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.
- However, if you have already asked us for a service authorization 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 of when you can make a complaint:
  - If you asked us to give you a fast service authorization or a fast appeal and we said we will not.
  - If you believe we are not meeting the deadlines for giving you a service authorization or an answer to an appeal you made.
  - When a service authorization we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs within certain deadlines and you think we are not meeting the deadlines.
  - When we do not give you a decision on time and we do not forward your case to the Hearing Office by the required deadline.
- **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.

Complaint Appeals

If you disagree with a decision we made about your complaint about your Medicaid benefits, you or someone you trust can file a **complaint appeal** with the plan.

How to make a complaint appeal:

- If you are not satisfied with what we decide, you have at least 60 workdays after hearing from us to file a complaint appeal;
- You can do this yourself or ask someone you trust to file the complaint appeal for you.
- You must make the complaint appeal in writing.
  - If you make an appeal by phone, you must follow it up in writing.
  - After your call, we will send you a form that summarizes your phone

appeal.

- If you agree with our summary, you must sign and return the form to us. You can make any needed changes before sending the form back to us.

What happens after we get your complaint appeal?
After we get your complaint appeal, we will send you a letter within 15 workdays. The letter will tell you:

- Who is working on your complaint appeal.
- How to contact this person.
- If we need more information.

One or more qualified people will review your complaint appeal. These reviewers are at a higher level than the reviewers who made the first decision about your complaint.

If your complaint appeal involves clinical matters, one or more qualified health professionals will review your case. At least one of them will be a clinical peer reviewer who was not involved in making the first decision about your complaint.

We will let you know our decision within 30 workdays from the time we have all information needed. If a delay would risk your health, you will get our decision in 2 workdays of when we have all the information, we need to decide the appeal. We will give you the reasons for our decision and our clinical rationale if it applies.

If you are still not satisfied, you or someone on your behalf can file a complaint at any time with the New York State Department of Health at 1-866 712-7197.

Participant Ombudsman
The Participant Ombudsman, called the Independent Consumer Advocacy Network (ICAN), is an independent organization that provides free ombudsman services to long term care recipients in the state of New York. You can call ICAN to get free, independent advice about your coverage, complaint, and appeal options. They can help you manage the appeal process.

Contact ICAN to learn more about their services:
Phone: 1-844-614-8800 (TTY Relay Service: 711) Web: www.icannys.org | Email: ican@cssny.org

DISENROLLMENT FROM VNS HEALTH TOTAL MAP PROGRAM

Enrollees shall not be disenrolled from the Medicaid Advantage Plus Product based on any of the following reasons:

- High utilization of covered medical services, an existing condition or a change in the Enrollee's health, ***or***
- diminished mental capacity or uncooperative or disruptive behavior resulting from his or her special needs unless the behavior results in the Enrollee becoming ineligible for Medicaid Advantage Plus.

You Can Choose to Voluntary Disenroll
You can ask to leave the VNS Health Total, MAP PROGRAM at any time for any reason.

To request disenrollment, call 1-866-783-1444 (TTY: 711). It could take up to six weeks to process, depending on when your request is received. You may disenroll to regular Medicaid or join another health plan as long as you qualify. If you continue to require Community Based Long Term Services and Supports (CBLTSS), like personal care, you must join another MLTC plan or Home and Community Based Waiver program, in order to continue to receive CBLTSS services.

You Will Have to Leave VNS Health Total, MAP Program if:

- You no longer are in VNS Health Total for your Medicare coverage,
- You are no longer Medicaid eligible,
- You need nursing home care, but are not eligible for institutional Medicaid,
- You are out of the plan's service area for more than 30 consecutive days,
- You permanently move out of VNS Health Tota*l s*ervice area,
- You are no longer eligible for nursing home level of care as determined using the Community Health Assessment (CHA), unless the termination of the services provided by the plan could reasonably be expected to result in you being eligible for nursing home level of care within the succeeding six-month period,
- At the point of any reassessment while living in the community, you are determined to no longer demonstrate a functional or clinical need for Community Based Long Term Services and Supports (CBLTSS),
- Your sole service is identified as Social Day Care,
- You join a Home and Community Based Services Waiver program, or become a resident of an Office for People with Developmental

Disabilities residential program.
- You become a resident of an Office of Mental Health, or Office of Addiction Services and Supports (OASAS) residential program (that is not a MAP plan covered benefit) for forty-five (45) consecutive days or longer.)

We May Ask You to Leave the VNS Health Total, MAP Program if:
- You or family member or informal caregiver or other person in the household engages in conduct or behavior that seriously impairs the plan's ability to furnish services.
- You knowingly provide fraudulent information on an enrollment form, or you permit abuse of an enrollment card in the MAP Program;
- You fail to complete and submit any necessary consent or release; or
- You fail to pay or make arrangements to pay the amount of money, as determined by the Local District of Social Services (LDSS), owed to the plan as spenddown/surplus within 30 days after amount first becomes due. We will have made reasonable effort to collect.

Before being involuntarily disenrolled, VNS Health Total will obtain the approval of New York Medicaid Choice (NYMC) or entity designated by the State. The effective date of disenrollment will be the first day of the month following the month in which the disenrollment is processed. If you continue to need CBLTSS, you will be required to choose another plan or you will be auto assigned to another plan to provide you with coverage for needed services.

CULTURAL AND LINGUISTIC COMPETENCY

VNS Health Total honors your beliefs and is sensitive to cultural diversity. We respect your culture and cultural identity and work to eliminate cultural disparities. We maintain an inclusive culturally competent provider network and promote and ensure delivery of services in a culturally appropriate manner to all enrollees. This includes but is not limited to those with limited English skills, diverse cultural and ethnic backgrounds, and diverse faith communities.

MEMBER RIGHTS AND RESPONSIBILITIES

VNS Health Total will make every effort to ensure that all members are treated with dignity and respect. At the time of enrollment, your Care Manager will explain your rights and responsibilities to you. If you require interpretation services, your Care Manager will arrange for them. Staff will make every effort

in assisting you with exercising your rights.

Member Rights

- You have the Right to receive medically necessary care.
- You have the Right to timely access to care and services.
- You have the Right to privacy about your medical record and when you get treatment.
- You have the Right to get information on available treatment options and alternatives presented in a manner and language you understand.
- You have the Right to get information in a language you understand; you can get oral translation services free of charge.
- You have the Right to get information necessary to give informed consent before the start of treatment.
- You have the Right to be treated with respect and dignity.
- You have the Right to get a copy of your medical records and ask that the records be amended or corrected.
- You have the Right to take part in decisions about your health care, including the right to refuse treatment.
- You have the Right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- You have the Right to get care without regard to gender, race, health status, color, age, national origin, sexual orientation, marital status or religion.
- You have the Right to be told where, when and how to get the services you need from your managed long term care plan, including how you can get covered benefits from out-of-network providers if they are not available in the plan network.
- You have the Right to complain to the New York State Department of Health or your Local Department of Social Services; and, the Right to request a fair hearing through the administrative Hearing Office and/or a New York State External Appeal, where appropriate.
- You have the Right to appoint someone to speak for you about your care and treatment.
- You have the Right to seek assistance from the Participant Ombudsman

program.

Member Responsibilities

- Receiving covered services through VNS Health Total.
- Using VNS Health Total network providers for covered services to the extent network providers are available.
- Obtaining prior authorization for covered services, except for pre-approved covered services or in emergencies;
- Being seen by your physician if a change in your health status occurs.
- Sharing complete and accurate health information with your health care providers;
- Informing VNS Health Total staff of any changes in your health, and making it known if you do not understand or are unable to follow instructions.
- Following the plan of care recommended by the VNS Health Total staff (with your input.)
- Cooperating with and being respectful with the VNS Health Total *s*taff and not discriminating against VNS Health Total staff because of race, color, national origin, religion, gender, age, mental or physical ability, sexual orientation or marital status.
- Notifying VNS Health Total within two business days of receiving non-covered or non-pre-approved services.
- Notifying your VNS Health Total health care team in advance whenever you will not be home to receive services or care that has been arranged for you.
- Informing VNS Health Total before permanently moving out of the service area, or of any lengthy absence from the service area.
- Your actions if you refuse treatment or do not follow the instructions of your caregiver.
- Meeting your financial obligations.

Advance Directives

Advance Directives are legal documents that ensure that your requests are fulfilled in the event you cannot make decisions for yourself. Advance directives can come in the form of a Health Care Proxy, a Living Will or a Do Not Resuscitate Order. These documents can instruct what care you wish to be given

under certain circumstances, and/or they can authorize a particular family member or friend to make decisions on your behalf.

It is your right to make advance directives as you wish. It is most important for you to document how you would like your care to continue if you are no longer able to communicate with providers in an informed way due to illness or injury. Please contact your Care Manager for assistance in completing these documents. If you already have an advanced directive, please share a copy with your Care Manager.

Information Available on Request

- Information regarding the structure and operation of VNS Health Total.
- Specific clinical review criteria relating to a particular health condition and other information that VNS Health Total considers when authorizing services.
- Policies and procedures on protected health information.
- Written description of the organizational arrangements and ongoing procedures of the quality assurance and performance improvement program.
- Provider credentialing policies.
- A recent copy of the VNS Health Total certified financial statement; and policies and procedures used by VNS Health Total to determine eligibility of a provider.

VNS Health Total Care Team

Call: 1-866-783-1444

Calls to this number are free. 7 days a week, 8 am – 8 pm (Oct. – Mar.), and Weekdays, 8 am – 8 pm (Apr. – Sept.). We also have free language interpreter services available for non-English speakers.

TTY: Please call the New York Relay Service at 711 and an operator will connect you. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 7 days a week, 8 am – 8 pm (Oct. – Mar.), and Weekdays, 8 am – 8 pm (Apr. – Sept.).

Write: VNS Health Health Plans

220 East 42nd Street
New York, NY 10017

Website: vnshealthplans.org

New York State Health Insurance Information Counseling and Assistance Program (HIICAP)

is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Call: 1-800-701-0501

TTY: Please call the New York Relay Service at 711 and an operator will connect you. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: Department for the Aging

Two Lafayette Street, 16th Floor
New York, NY 10007-1392

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

VNS Health

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