

**January 1 – December 31, 2026**

## **Evidence of Coverage for 2026:**

### **Your Medicare Health Benefits and Services and Drug coverage as a Member of Senior Whole Health Medicare Complete Care (HMO D-SNP)**

This document gives you the details about your Medicare and drug coverage from January 1 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

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

**For questions about this document, call Member Services at (833) 671-0440. (TTY users call 711). Hours are October 1 – March 31, 8 a.m. – 8 p.m. local time, 7 days a week. From April 1 – September 30, Monday – Friday, 8 a.m. – 8 p.m. local time. This call is free.**

This plan, Senior Whole Health Medicare Complete Care (HMO D-SNP), is offered by Senior Whole Health of New York, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Senior Whole Health of New York, Inc. When it says “plan” or “our plan,” it means Senior Whole Health Medicare Complete Care (HMO D-SNP).

Senior Whole Health complies with applicable Federal civil rights laws and does not discriminate on the basis of race, ethnicity, national origin, religion, gender, sex, age, mental or physical disability, health status, receipt of healthcare, claims experience, medical history, genetic information, evidence of insurability, geographic location.

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Benefits may change on January 1, 2027.

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

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# CHAPTER 1:

## Get started as a member

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### SECTION 1 You're a member of Senior Whole Health Medicare Complete Care (HMO D-SNP)

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#### Section 1.1 You're enrolled in Senior Whole Health Medicare Complete Care (HMO D-SNP) which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

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

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

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

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

Senior Whole Health Medicare Complete Care (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. Our plan also has a contract with the New York Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare coverage, including drug coverage.

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

### **Section 1.3 Legal information about the Evidence of Coverage**

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

The contract is in effect for the months you're enrolled in Senior Whole Health Medicare Complete Care (HMO D-SNP) between January 1, 2026, and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Senior Whole Health Medicare Complete Care (HMO D-SNP) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) must approve Senior Whole Health Medicare Complete Care (HMO D-SNP) each year. You can continue each year to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

## **SECTION 2 Plan eligibility requirements**

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### **Section 2.1 Eligibility requirements**

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they're physically located in it.

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- You're a United States citizen or lawfully present in the United States
- 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 get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources.) To be eligible for our plan you must be eligible for both Medicare and Full Medicaid Benefits

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6 month(s), then you're still eligible for membership. Chapter 4, Section 2.1 tells you about coverage and cost sharing during a period of deemed continued eligibility.

### Section 2.2 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's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

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

- **Full Benefit Dual Eligible (FBDE):** An individual who is entitled to Medicare, does not meet the income or resource criteria for QMB+ or SLMB+, but is eligible for full Medicaid coverage either categorically or through optional coverage groups based on Medically Needy status, special income levels for institutionalized individuals, or home and community-based Waivers.
- **Qualified Medicare Beneficiary (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). These individuals are also eligible for full Medicaid benefits.

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**Section 2.3 Plan service area for Senior Whole Health Medicare Complete Care (HMO D-SNP)**

Senior Whole Health Medicare Complete Care (HMO D-SNP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area.

Our service area includes these counties in New York: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, and Westchester.

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 move out of our plan's service area, you can't stay a member of this plan. Call Member Services (833) 671-0440 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

**Section 2.4 U.S. citizen or lawful presence**

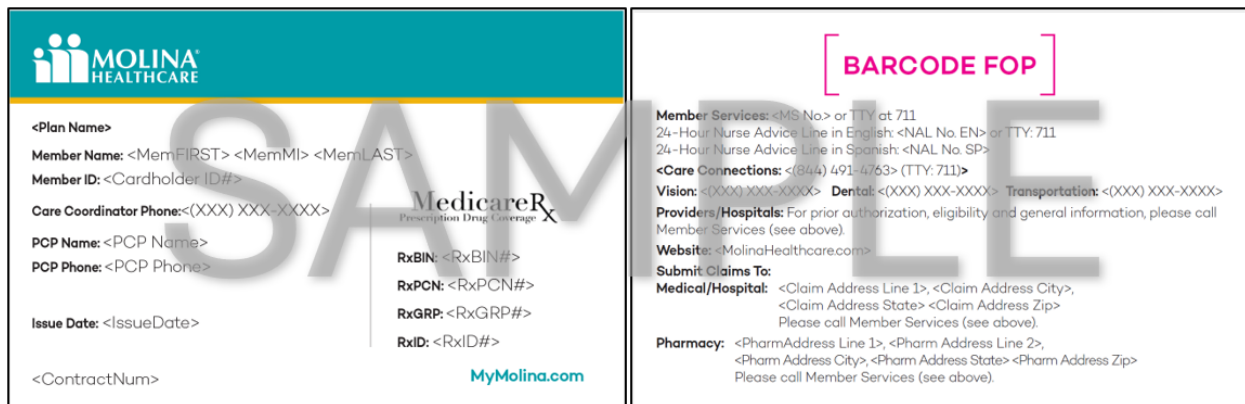
You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Senior Whole Health Medicare Complete Care (HMO D-SNP) if you're not eligible to stay a member of our plan on this basis. Senior Whole Health Medicare Complete Care (HMO D-SNP) must disenroll you if you don't meet this requirement.

**SECTION 3 Important membership materials**

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**Section 3.1 Our plan membership card**

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. Always remember to show both your Senior Whole Health Medicare Complete Care (HMO D-SNP) ID card and Medicaid ID card each time you present for care. 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're a member of this plan. If you use your Medicare card instead of your Senior Whole Health Medicare Complete Care (HMO D-SNP) membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services (833) 671-0440 (TTY users call 711) right away and we'll send you a new card.

### Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory SWHNY.com* 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'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when Senior Whole Health Medicare Complete Care (HMO D-SNP) authorizes use of out-of-network providers.

The *Pharmacy Directory SWHNY.com* lists our network pharmacies.

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

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plan's network. The most recent list of providers, pharmacies and suppliers is available on our website at [SWHNY.com](http://SWHNY.com).

If you don't have a *Provider/Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services (833) 671-0440 (TTY users call 711). Requested paper Provider Directories will be mailed to you within 3 business days.

The *Pharmacy Directory* [SWHNY.com](http://SWHNY.com) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5 for information on when you can use pharmacies that aren't in our plan's network.

**Section 3.4 Drug List (formulary)**

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

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit the plan's website ([SWHNY.com](http://SWHNY.com)) or call Member Services (833) 671-0440 (TTY 711).

**SECTION 4 Your monthly costs for Senior Whole Health Medicare Complete Care (HMO D-SNP)**

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	<b>Your Costs in 2026</b>
<b>Maximum out-of-pocket amount</b> This is the <u>most</u> you'll pay out-of-pocket for covered Part A and Part B services. (Go to Chapter 4 Section 1 for details.)	<b>\$9,250</b>  <b>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.</b>

	<b>Your Costs in 2026</b>
<b>Primary care office visits</b>	<b>\$0 per visit</b> <b>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</b>
<b>Specialist office visits</b>	<b>\$0 per visit</b> <b>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0 per visit.</b>
<b>Inpatient hospital stays</b>	<b>\$0</b> <b>If you are eligible for Medicare cost-sharing help under Medicaid, you pay \$0.</b>

**Your Costs in 2026**

**Part D drug coverage deductible**

(Go to Chapter 6 Section 4 for details.)

The deductible is \$199 except for covered insulin products and most adult Part D vaccines. During this stage, you pay \$0 cost sharing for drugs on Tier 1 and Tier 6 and the applicable cost of drugs on Tier 2, Tier 3, Tier 4 and Tier 5 until you have reached the yearly deductible.

**Copayment during the Initial Coverage Stage:**

***Drug Tier 1: \$0***

***Drug Tier 2: \$0, \$1.60, or \$2 copay for all drugs per prescription.***

***Drug Tier 3: \$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription.***

***Drug Tier 4: \$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription.***

***Drug Tier 5: \$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription.***

***Drug Tier 6: \$0***

## Your Costs in 2026

### Part D drug coverage

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

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

Your costs may include the following:

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

### Section 4.1 Plan premium

As a member of our plan, you pay a monthly plan premium. For 2026, the monthly plan premium for Senior Whole Health Complete Care (HMO D-SNP) is \$12.50.

If you *already* get help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you.** We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at (833) 671-0440 (TTY users call 711) and ask for the *LIS Rider*.

**In some situations, our plan premium could be less.**

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

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the *Medicare & You 2026* handbook in the section called *2026 Medicare Cost*. Download a copy from the Medicare website ([www.Medicare.gov/medicare-and-you](http://www.Medicare.gov/medicare-and-you)) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

**Section 4.2 Monthly Medicare Part B Premium**

**Many members are required to pay other Medicare premiums**

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

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

**Section 4.3 Part D Late Enrollment Penalty**

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

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

- You get Extra Help from Medicare to help pay your drug costs.

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

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

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you did not have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2025 this average premium amount was \$36.78. This amount may change for 2026.
- 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 \$36.78, which equals \$5.15. This rounds to \$5.20. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

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

- **The penalty may change each year**, because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're under 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based

only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

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

#### **Section 4.4 Income Related Monthly Adjustment Amount**

If you lose eligibility for this plan because of changes in income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit [www.Medicare.gov/health-drug-plans/part-d/basics/costs](http://www.Medicare.gov/health-drug-plans/part-d/basics/costs).

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

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

#### **Section 4.5 Medicare Prescription Payment Plan Amount**

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

**Chapter 1 Get started as a member**

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

**SECTION 5 More information about your monthly plan premium**

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**Section 5.1 Our monthly plan premium won't change during the year**

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

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

**SECTION 6 Keep our plan membership record up to date**

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

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

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

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes

## Chapter 1 Get started as a member

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- If you participate in a clinical research study (**Note:** You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services (833) 671-0440 (TTY users call 711). Members can create an online My Senior Whole Health account to change their doctor, update their contact information, request a new ID card, get health reminders on services they need, or view their service history. Visit <https://member.molinahealthcare.com/member/LoginNY> to create or access your My Senior Whole Health account.

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

## SECTION 7 How other insurance works with our plan

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### Other insurance

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services (833) 671-0440 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the number of people employed by your employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):

**Chapter 1 Get started as a member**

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- If you're under 65 and disabled and you (or your family member) are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
- If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

# CHAPTER 2:

## Phone numbers and resources

### SECTION 1 Senior Whole Health Medicare Complete Care (HMO D-SNP) contacts

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For help with claims, billing, or member card questions, call or write to Senior Whole Health Medicare Complete Care (HMO D-SNP) Member Services. We'll be happy to help you.

#### Member Services – Contact Information

<b>Call</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. local time. Member Services (833) 671-0440 (TTY users call 711) also has free language interpreter services for non-English speakers.
<b>TTY</b>	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. local time.
<b>Fax</b>	(310) 507-6186
<b>Write</b>	Molina Healthcare Attn: Member Services 15 MetroTech Center, 11th Floor Brooklyn, NY 11201
<b>Website</b>	<a href="http://SWHNY.com">SWHNY.com</a>

### How to ask for a coverage decision or appeal about your medical care

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

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

<b>Call</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>TTY</b>	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. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>Fax</b>	Advanced Imaging: (877) 731-7218; Transplants (877) 813-1206; Medical/Behavioral Health Outpatient (844) 251-1450; Inpatient (844) 834-2152; RX/Jcodes (866) 290-1309
<b>Write</b>	Molina Healthcare Attn: Coverage Request 200 Oceangate, Suite 100 Long Beach, CA 90802  <b>Prescription Drug:</b>  Attn: Medicare Pharmacy Department 7050 Union Park Center, Suite 200 Midvale, UT 84047
<b>Website</b>	<a href="http://SWHNY.com">SWHNY.com</a>

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

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

**Complaints about Medical Care – Contact Information**

<b>Call</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>TTY</b>	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. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>Fax</b>	(562) 499-0610
<b>Write</b>	Molina Healthcare Attn: Appeals & Grievances P.O. Box 22816 Long Beach, CA 90801-9977
<b>Medicare website</b>	<a href="http://SWHNY.com">SWHNY.com</a>

**How to ask us to pay the cost for medical care or a drug you got**

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

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

**Payment Requests – Contact Information**

<b>Call</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m., local time.
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**Chapter 2 Phone numbers and resources**

<b>TTY</b>	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>Fax</b>	(866) 290-1309
<b>Write</b>	Molina Healthcare Attn: Pharmacy Department 7050 Union Park Center, Suite 600 Midvale, UT 84047  <b>Prescription Drug:</b>  Attn: Medicare Pharmacy Department 7050 Union Park Center, Suite 200 Midvale, UT 84047
<b>Website</b>	<a href="http://SWHNY.com">SWHNY.com</a>

**SECTION 2 Get help from Medicare**

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

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

**Medicare – Contact Information**

<b>Call</b>	1-800-MEDICARE (1-800-633-4227)  <b>24 hours a day, 7 days a week.</b>
<b>TTY</b>	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.

**Chapter 2 Phone numbers and resources**

<b>Call</b>	1-800-MEDICARE (1-800-633-4227)  <b>24 hours a day, 7 days a week.</b>
<b>Chat Live</b>	Chat live at <a href="http://www.Medicare.gov/talk-to-someone">www.Medicare.gov/talk-to-someone</a> .
<b>Write</b>	<ul style="list-style-type: none"> <li>• Write to Medicare at PO Box 1270, Lawrence, KS 66044</li> </ul>
<b>Website</b>	<p><a href="http://www.Medicare.gov">www.Medicare.gov</a></p> <ul style="list-style-type: none"> <li>• Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide.</li> <li>• Find Medicare-participating doctors or other health care providers and suppliers.</li> <li>• Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits).</li> <li>• Get Medicare appeals information and forms.</li> <li>• Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals.</li> <li>• Look up helpful websites and phone numbers.</li> </ul> <p>You can also visit <a href="http://www.Medicare.gov">www.Medicare.gov</a> to tell Medicare about any complaints you have about Senior Whole Health Medicare Complete Care (HMO D-SNP):</p> <p><b>To submit a complaint to Medicare,</b> go to <a href="http://www.Medicare.gov/my/medicare-complaint">www.Medicare.gov/my/medicare-complaint</a>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.</p>

**SECTION 3 State Health Insurance Assistance Program (SHIP)**

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

## Chapter 2 Phone numbers and resources

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

Health Insurance Information, Counseling and Assistance Program (HIICAP) counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems with your Medicare bills. Health Insurance Information, Counseling and Assistance Program (HIICAP) counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

### Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York's SHIP) – Contact Information – Contact Information

<b>Call</b>	(800) 701-0501
<b>Write</b>	New York State Office for the Aging 2 Empire State Plaza Albany, New York 12223-1251
<b>Website</b>	<a href="https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap">https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap</a>

## SECTION 4 Quality Improvement Organization (QIO)

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

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

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

**Livanta (New York’s Quality Improvement Organization) – Contact Information**

<b>Call</b>	(866) 815-5440 Monday - Friday from 9:00 a.m. to 5:00 p.m. local time; weekends and holidays from 10:00 a.m. to 4:00 p.m. local time.
<b>TTY</b>	711: This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	Livanta BFCC-QIO Program 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701
<b>Website</b>	<a href="https://www.livantaqio.com/">https://www.livantaqio.com/</a>

**SECTION 5 Social Security**

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

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

**Social Security– Contact Information**

<b>Call</b>	1-800-772-1213 Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. Use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.
<b>TTY</b>	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.

<b>Website</b>	<a href="http://www.SSA.gov">www.SSA.gov</a>
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## **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. 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:

- Full Benefit Dual Eligible (FBDE):** At times, individuals may qualify for both limited coverage of Medicare cost-sharing as well as full Medicaid benefits.
- Qualified Medicare Beneficiary (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). These individuals are also eligible for full Medicaid benefits.

To be a member of this plan, you should be dually enrolled in Medicare and Medicaid and meet all other plan eligibility requirements at the time of enrollment.

If you have questions about the help you get from Medicaid, contact

### **New York State Medicaid Program**

#### **– Contact Information**

<b>Call</b>	<b><i>1-800-541-2831 Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM</i></b>
<b>TTY</b>	<i>711</i> This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	<i>You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: <a href="http://www.health.ny.gov/health_care/medicaid/ldss">www.health.ny.gov/health_care/medicaid/ldss</a></i>
<b>Website</b>	<i><a href="http://www.health.ny.gov/health_care/medicaid">www.health.ny.gov/health_care/medicaid</a></i>

Nassau County members may contact the local Department of Social Services.

<b>Method</b>	<b>Nassau County Department of Social Services</b>
<b>CALL</b>	(516) 227-7474
<b>WRITE</b>	Nassau County DSS 60 Charles Lindbergh Blvd. Uniondale, NY 11553-3656
<b>WEBSITE</b>	<a href="https://www.nassaucountyny.gov/agencies/dss/medicaid/index.html">https://www.nassaucountyny.gov/agencies/dss/medicaid/index.html</a>

Westchester County members may contact the local Department of Social Services.

<b>Method</b>	<b>Westchester County Department of Social Services</b>
<b>CALL</b>	(914) 995-3333
<b>WRITE</b>	White Plains District Office 85 Court Street White Plains, NY 10601-4201
<b>WEBSITE</b>	<a href="http://socialservices.westchestergov.com/about-us/dss-district-offices">http://socialservices.westchestergov.com/about-us/dss-district-offices</a>

The *Independent Consumer Advocacy Network (ICAN)* helps people enrolled in Medicaid with service or billing problems. They can help you file a grievance or appeal with our plan. This

**Chapter 2 Phone numbers and resources**

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

**Independent Consumer Advocacy Network (ICAN) – Contact Information**

<b>Call</b>	<i>1-844-614-8800 Mon.-Fri. 9:00 AM - 5:00 PM</i>
<b>TTY</b>	<i>711</i> This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	<i>Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017 EMAIL: <a href="mailto:ican@cssny.org">ican@cssny.org</a></i>
<b>Website</b>	<i><a href="http://www.icannys.org">www.icannys.org</a></i>

**Community Health Advocates (CHA) – Contact Information**

<b>Call</b>	<i>1-888-614-5400 Mon.-Fri. 9:00 AM - 4:00 PM</i>
<b>TTY</b>	<i>711</i> This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	<i>Community Health Advocates (CHA) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017 EMAIL: <a href="mailto:cha@cssny.org">cha@cssny.org</a></i>
<b>Website</b>	<i><a href="http://www.communityhealthadvocates.org">www.communityhealthadvocates.org</a></i>

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

<b>Call</b>	<i>1-888-614-5400 Mon.-Wed. 9:00 AM – 7:00 PM, Thurs.-Fri. 9:00 AM – 4:00 PM</i>
<b>TTY</b>	<i>711</i> This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
<b>Write</b>	<i>Community Health Access to Addiction and Mental Healthcare Project (CHAMP)</i>  <i>Community Service Society of New York</i>  <i>633 Third Ave, 10th Floor</i>  <i>New York, NY 10017</i>  <i>EMAIL: ombuds@oasas.ny.gov</i>
<b>Website</b>	<i>www.champny.org</i>

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

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

<b>Call</b>	<i>1-855-582-6769 Mon.-Fri. 9:00 AM – 5:00 PM</i>
<b>Write</b>	<i>2 Empire State Plaza, 5th Floor</i>  <i>Albany, NY 12223</i>  <i>EMAIL: ombudsman@aging.ny.gov</i>
<b>Website</b>	<i>www.aging.ny.gov/long-term-care-ombudsman-program</i>

**SECTION 7 Programs to help people pay for prescription drugs**

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

## Chapter 2 Phone numbers and resources

### Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't 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 call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office (See Section 6 of this chapter for contact information).

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

- The Best Available Evidence (BAE) located on the web at <https://www.cms.gov/medicare/enrollment-renewal/part-d-prescribers/best-available-evidence-bae>. BAE is used to determine a member's Low Income Subsidy. Our Member Services department and Pharmacy department identify cases where the BAE policy applies. Members may send BAE documentation to establish eligibility to the Member Services address listed in Chapter 2. Additionally you may contact Member Services if you have questions. Acceptable forms of evidence are:
  - SSA Award Letter
  - Notice of Award
  - Supplemental Security Income
- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at (833) 671-0440 (TTY users call 711) if you have questions.

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

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

**Chapter 2 Phone numbers and resources**

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

**EPIC (Elderly Pharmaceutical Insurance Coverage) (New York's State Pharmaceutical Assistance Program) – Contact Information**

<b>Call</b>	(800) 332-3742 Monday - Friday, 8 a.m. - 5 p.m., local time
<b>Write</b>	EPIC P.O. Box 15018 Albany, NY 12212-5018
<b>Website</b>	<a href="https://www.health.ny.gov/health_care/epic/">https://www.health.ny.gov/health_care/epic/</a>

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

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the New York State-specific ADAP information.

**Note:** To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call 800) 842-2437 or (844) 682-4058.

**State Pharmaceutical Assistance Programs**

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

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

**EPIC (Elderly Pharmaceutical Insurance Coverage) (New York's State Pharmaceutical Assistance Program) – Contact Information**

<b>Call</b>	(800) 332-3742 Monday - Friday, 8 a.m. - 5 p.m., local time
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<b>Write</b>	EPIC P.O. Box 15018 Albany, NY 12212-5018
<b>Website</b>	<a href="https://www.health.ny.gov/health_care/epic/">https://www.health.ny.gov/health_care/epic/</a>

**Medicare Prescription Payment Plan**

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn’t save you money or lower your drug costs. If you’re participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan. To learn more about this payment option, call Member Services at (833) 671-0440 (TTY users call 711) or visit [www.Medicare.gov](http://www.Medicare.gov).

**Medicare Prescription Payment Plan – Contact Information**

<b>Call</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. local time. Member Services (833) 671-0440 (TTY users call 711) also has free language interpreter services for non-English speakers.
<b>TTY</b>	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m. local time.
<b>Fax</b>	(310) 507-6186
<b>Write</b>	Molina Healthcare Attn: Member Services 15 MetroTech Center, 11th Floor Brooklyn, NY 11201
<b>Website</b>	<a href="http://SWHNY.com">SWHNY.com</a>

## SECTION 8 Railroad Retirement Board (RRB)

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

### Railroad Retirement Board (RRB) – Contact Information

<b>Call</b>	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
<b>TTY</b>	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
<b>Website</b>	<a href="https://RRB.gov">https://RRB.gov</a>

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## SECTION 9 If you have group insurance or other health insurance from an employer

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If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at (833) 671-0440 (TTY users call 711) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

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

# CHAPTER 3:

## Using our plan for your medical and other covered services

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

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This chapter explains what you need to know about using our plan to get your medical care and other services covered. For details on what medical care and other services our plan the *Medical Benefits Chart* in Chapter 4.

#### Section 1.1 Network providers and covered services

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

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

As a Medicare and Medicaid health plan, Senior Whole Health Medicare Complete Care (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare.

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

Senior Whole Health Medicare Complete Care (HMO D-SNP) will generally cover your medical care as long as:

- **The care you get is included in our plan’s Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.1 for more information).
  - In most situations, our plan must give you approval in advance (a referral) before you can use other providers in our plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health **care** agencies. For more information, go to Section 2.3.
  - You don’t need referrals **from** your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (see Section 2). In most cases, care you get from an out-of-network provider (a provider who’s not part of our plan’s network) won’t be covered. This means that you have to pay the provider in full for services you get. *Here are 3 exceptions:*
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. *In this case prior authorization is required. Please contact member services for assistance.* In this situation, we’ll cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you’re outside our plan’s service area and get dialysis from a provider outside our plan’s network, your cost sharing can’t be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services

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

inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

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

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**Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your care****What is a PCP and what does the PCP do for you?**

When you become a member of Senior Whole Health Medicare Complete Care (HMO D-SNP), you are required to choose a primary care provider (PCP). Your PCP is a licensed provider who meets state requirements and is trained to give you basic medical care.

Your PCP is a New York State Family Medicine, Internal Medicine, Geriatric Medicine, Adult Medicine or Family Medicine physician, or a Gerontological Nurse Practitioner. You will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member. This includes x-rays, laboratory tests, therapies, care from specialists, hospital admissions and follow-up care. "Coordinating" your services also involves checking or consulting with other plan providers about your care. In some cases, your PCP also need to get prior authorization (prior approval) from our plan. The Benefits Chart in Chapter 4 shows which services need prior authorization from the plan. Your PCP will contact Senior Whole Health Medicare Complete Care (HMO D-SNP) to get the necessary authorization. Since your PCP will provide and coordinate your medical care, you should have all your past medical records sent to your PCP's office.

**How to choose a PCP**

When you sign up for our plan you will be asked to select a PCP. The PCP you currently see might already be part of the Senior Whole Health Medicare Complete Care (HMO D-SNP) network. When you apply for our plan, we'll find out whether your PCP is part of our plan. If your doctor is not part of Senior Whole Health Medicare Complete Care (HMO D-SNP), you will need to choose a new one from our network and set up an appointment to see that doctor as soon as possible.

You can choose your PCP from the Senior Whole Health Medicare Complete Care (HMO D-SNP) Provider and Pharmacy Directory at the time you sign up. For the most current list of providers, use the Find a Provider search tool on our website. You can also contact Member Services at the toll-free number on the back of this booklet. We will review the names of PCPs in your area, ask you about other doctors you see and which hospitals you go to. You will be asked to put the PCP's name on your enrollment application. You can change your PCP any time.

### **How to change your PCP**

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

Senior Whole Health Medicare Complete Care (HMO D-SNP) has a Continuity-of-Care (COC) Policy that allows you continued access to non-contracted practitioners in the following situations:

#### **If you are a new member, you may continue treatment for up to 90 days:**

- If you are in an active course of treatment with a non-contracted practitioner/s at the time of enrollment.
- If you have current DME equipment- Senior Whole Health Medicare Complete Care (HMO D-SNP) will ensure continued access to needed DME and repairs from non-contracted providers.
- If you are pregnant you will receive continuity of care until postpartum services are completed or for a longer period if necessary for safe transfer to another provider.

**If you are an existing member** you may receive continuity of care for up to a year for ongoing services upon discontinuation of a contract between Senior Whole Health Medicare Complete Care (HMO D-SNP) and your practitioner or facility, provided the following caveats:

- Services are part of your benefits.
- The provider was not discontinued due to quality of care issues.
- The provider has to agree to continue seeing you.
- The provider has agreed to accept the regulatory required rates.

Senior Whole Health Medicare Complete Care (HMO D-SNP) staff will work with your non-contracted practitioner to bring them into the Senior Whole Health Medicare Complete Care (HMO D-SNP) network as a contracted provider or work with you and the provider to transition your care to a practitioner within the network during the 90 day continuity-of-care time period. Continuity of care will be provided within the limits of your benefits.

### **Exceptions to Policy:**

1. Senior Whole Health Medicare Complete Care (HMO D-SNP) staff may extend the 90 day period as long as necessary to meet any unusual needs you may have.
2. Senior Whole Health Medicare Complete Care (HMO D-SNP) will not approve continued care by a non-participating provider if:
  - You only require monitoring of a chronic condition.
  - The discontinued contract with the practitioner is based on a professional review action for incompetence or inappropriate conduct, and your welfare might be in jeopardy.

### **Section 2.2 Medical care and other services you can get without a PCP referral**

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

- Routine women’s health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you’re either temporarily outside our plan’s service area, or if it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you’re temporarily outside our plan’s service area. If possible, call Member Services at (833) 671-0440 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you’re 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. For example:

- Oncologists care for patients with cancer
- Cardiologists care for patients with heart conditions

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

- Orthopedists care for patients with certain bone, joint, or muscle conditions

Your PCP is responsible for coordinating services, including directing you to specialists and other network providers as appropriate. There is no prior approval requirement for office visits with network specialists. If you need a procedure or a service that requires plan prior authorization, your PCP or specialist will contact us to get the necessary prior authorization. Services that require plan prior authorization are identified in Chapter 4, Section 2.1 of this document. Examples of services that require plan prior authorization include elective (non-emergency) inpatient hospital care, admissions to a skilled nursing facility, and home health care.

If you need care after normal business hours, please call your PCP. This information is listed on your Senior Whole Health Medicare Complete Care (HMO D-SNP) membership ID card. If you think it is an emergency, seek medical attention immediately. For more information, see Section 3, (How to get covered services when you have an emergency or urgent need for care).

#### **When a specialist or another network provider leaves our plan**

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. Prior authorization may be required.

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

- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

If you need specialized medical care that Medicare or Medicaid requires our plan to cover and there are no providers in our network who can provide this care, you can get the care from an out-of-network provider. This includes the services of a provider who is uniquely qualified to provide the particular service you need, as well as services provided at a specialty center or a center of excellence (e.g., ESRD services). There are no additional benefit restrictions that apply outside of our network or service area.

Either you or your PCP must contact our plan for prior authorization before seeking care from out-of-network providers. Call Member Services for help. If we give you prior authorization to get care from an out-of-network provider, we will cover these services as if you got the care from a network provider.

It is very important to get a prior authorization from our plan before you see out-of-network providers. If you don't have plan approval, our plan may not cover these services. If the provider wants you to come back for more care, check first to be sure the approval from our plan covers more than one visit to the out-of-network provider.

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

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

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### Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they're not part of our network
- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Member Services at the *phone number and days and hours of operation or explain where to find the number (e.g., on the back of our plan membership card).*

### **Covered services in a medical emergency**

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

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

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

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

### **What if it wasn't a medical emergency?**

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

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

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

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

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

When network providers are temporarily unavailable or inaccessible, urgent care can be accessed using any available urgent care center. You may also call the Nurse Advice Line at (877) 353-0185. TTY users should call 711.

Our plan covers worldwide emergency care services outside the United States under the following circumstances:

- You have a limit of \$10,000 for worldwide emergency coverage each calendar year to use towards emergency care, and post-stabilization care.
- This benefit is limited to services that would be classified as emergency care had the care been provided in the U.S.
- If you receive emergency care outside the U.S. and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan. Your cost is the cost-sharing you would pay at a network hospital. Plan maximum applies.
- You may need to pay for services out-of-pocket and file a claim for reimbursement.
- Foreign taxes and fees (including but not limited to, currency conversion or transaction fees) are not covered. Transportation back to the U.S. from another country is not covered.
- Routine care and pre-scheduled or elective procedures are not covered.

If you have questions about whether we will pay for any services, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover the service(s), you have the right to appeal our decision not to cover or reimburse your care.

### **Section 3.3 Get care during a disaster**

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

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

Visit [SWHNY.com](http://SWHNY.com) for information on how to get needed care during a disaster.

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

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

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

#### Section 4.1 If services aren't covered by our plan

Senior Whole Health Medicare Complete Care (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

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

### SECTION 5 Medical services in a clinical research study

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#### Section 5.1 What is a clinical research study

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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.

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

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

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

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

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

#### Section 5.2 Who pays for services in a clinical research study

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

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

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

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

### **Get more information about joining a clinical research study**

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies*, available at [www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf](http://www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf).) You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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### **Section 6.1 A religious non-medical health care institution**

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

- Medicare *Inpatient Hospital* coverage limits *apply*

Additionally, you should contact Member Services or your State Medicaid office (the contact information is listed in Chapter 2, Section 6) for more information on Medicaid-covered services to understand all your coverage options.

## **SECTION 7 Rules for ownership of durable medical equipment**

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### **Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan**

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Senior Whole Health Medicare Complete Care (HMO D-SNP), however, you usually **won't get** ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. You won't get ownership, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at (833) 671-0440 (TTY users call 711) for more information.

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

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

**Example 1:** You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item

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

## **Section 7.2 Rules for oxygen equipment, supplies, and maintenance**

If you qualify for Medicare oxygen equipment coverage Senior Whole Health Medicare Complete Care (HMO D-SNP) will cover:

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

If you leave Senior Whole Health Medicare Complete Care (HMO D-SNP) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

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

# CHAPTER 4:

## Medical Benefits Chart

### (what's covered)

#### SECTION 1 Understanding covered services

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The Medical Benefits Chart lists your covered services as a member of Senior Whole Health Medicare Complete Care (HMO D-SNP). This section also gives information about medical services that aren't covered and explains limits on certain services.

##### 1.1 You pay nothing for your covered services

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

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

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

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is \$9,250.**

The amounts you pay for covered services count toward this maximum out-of-pocket amount. The amounts you pay for plan premiums and Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk (\*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of \$9,250, you won't have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

## Chapter 4 Medical Benefits Chart (what's covered)

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

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

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

Other important things to know about our coverage:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including inpatient hospital services and outpatient hospital services. Medicaid also covers services Medicare doesn't cover, like family planning services, long-term care, over-the-counter drugs, home and community-based services, or other Medicaid-only services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You*

## Chapter 4 Medical Benefits Chart (what's covered)

2026 handbook. View it online at [www.Medicare.gov](http://www.Medicare.gov) or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those 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. This means that for covered services, you will not have to pay any cost-share (no co-pays or deductibles). As a member of Senior Whole Health Medicare Complete Care (HMO D-SNP), we coordinate your Medicare covered services and your Medicaid services as they are both covered by our plan. The benefit information below includes Medicare and Medicaid covered services.
- If you're within our plan's 6-month (180 days) period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we *won't* 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.

**If you're eligible for Medicare cost-sharing help under Medicaid, you don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.**

## Important Benefit Information for Enrollees with Chronic Conditions

- If you're diagnosed with any of the chronic condition(s) listed below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.
  - Chronic alcohol use disorder and other substance use disorders (SUDs)
  - Autoimmune disorders
  - Cancer
  - Cardiovascular disorders
  - Chronic heart failure
  - Dementia
  - Diabetes mellitus
  - Overweight, obesity, and metabolic syndrome
  - Chronic gastrointestinal disease
  - Chronic kidney disease (CKD)
  - Severe hematologic disorders

#### Chapter 4 Medical Benefits Chart (what's covered)

- o HIV/AIDS
- o Chronic lung disorders
- o Chronic and disabling mental health conditions
- o Neurologic disorders
- o Stroke
- o Post-organ transplantation
- o Immunodeficiency and Immunosuppressive disorders
- o Conditions associated with cognitive impairment
- o Conditions with functional challenges
- o Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- o Conditions that require continued therapy services in order for individuals to maintain or retain functioning


We will help you with accessing these benefits. You can call Member Services or your Care Coordinator to initiate your request or get additional information.

Note: By requesting this benefit you are authorizing Senior Whole Health of New York representatives to contact you by phone, mail or any other methods of communication as expressly outlined in your application.

- For more detail, go to the *Special Supplemental Benefits for the Chronically Ill* row in the Medical Benefits Chart below.
- Contact us to find out exactly which benefits you may be eligible for.

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

#### Medical Benefits Chart

Covered Service	What you pay
<p> <b>Abdominal aortic aneurysm screening</b></p> <p>A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p>	<p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.</p>
<p><b>Acupuncture for chronic low back pain</b></p> <p>Covered services include:</p> <p>Up to 12 visits in 90 days are covered under the following circumstances:</p>	<p>There is no coinsurance or copayment for Medicare-covered acupuncture services.</p>

**Chapter 4 Medical Benefits Chart (what's covered)**

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.

**Prior authorization may be required.**

An additional **8** sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually.

Treatment must be discontinued if the patient is not improving or is regressing.

**Provider Requirements:**

Physicians (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 master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and,
- a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia.

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.

## Chapter 4 Medical Benefits Chart (what's covered)

### Acupuncture Services (Supplemental)\*

Plan maximum of up to 30 medically necessary visits every calendar year for acupuncture services.

Supplemental acupuncture services are covered when determined as medically accepted standard of care for:

- Headache; hip or knee joint pain associated with osteoarthritis (OA); or other extremity joint pain when chronic and unresponsive to standard medical care; pain syndromes involving the joints and associated soft tissues; musculoskeletal neck and back pain; nausea associated with chemotherapy; post-surgical nausea; and nausea associated with pregnancy
- Covered acupuncture services do not include services for the treatment of asthma or addiction (including without limitation, smoking cessation)

There is no coinsurance, copayment or deductible for these services.

### Ambulance services

- Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.

There is no coinsurance or copay for Medicare-covered ambulance services.

**Prior authorization required for non-emergent ambulance only.**



### 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.

There is no coinsurance, copayment, or deductible for the annual wellness visit.

## Chapter 4 Medical Benefits Chart (what's covered)

**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.

### **Bone mass measurement**

For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

### **Breast cancer screening (mammograms)\***

Covered services include:

- o One baseline mammogram between the ages of 35 and 39
- o One screening mammogram every 12 months for women aged 40 and older
- o Clinical breast exams once every 24 months

A screening mammography is used for the early detection of breast cancer. Once a history of breast cancer has been established, and until there are no longer any signs or symptoms of breast cancer, ongoing mammograms are considered diagnostic and are covered under "Outpatient diagnostic tests and therapeutic services and supplies" in this chart. The screening mammography annual benefit is not available for members who have signs or symptoms of breast cancer.

There is no coinsurance, copayment, or deductible for covered screening mammograms.

### **Cardiac rehabilitation services**

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order.

Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.

There is no coinsurance, copayment, or deductible for these services.

**Prior authorization may be required.**

**Chapter 4 Medical Benefits Chart (what's covered)****Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)\***

We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.

There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.

**Cardiovascular disease screening tests**

Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).

There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

**Cervical and vaginal cancer screening**

Covered services include:

- For all women: Pap tests and pelvic exams are covered once every 24 months
- If you're at high risk of cervical or vaginal cancer or you're 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 (Medicare-covered)**

Covered services include:

- Manual manipulation of the spine to correct subluxation

There is no coinsurance, copayment, or deductible for these services.

**Chronic pain management and treatment services**

Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.

There is no coinsurance, copayment, or deductible for 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

There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam, excluding

**Chapter 4 Medical Benefits Chart (what's covered)**

- months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema.
- o Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed.
  - o Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient got a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema.
  - o Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months.
  - o Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
  - o Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years.
  - o 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.
- 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.
- The Part B deductible doesn't apply.
- If an abnormality is detected during a screening and action is taken by the provider at that time, the additional services (biopsy or other intervention) is then considered a diagnostic exam.

**Chapter 4 Medical Benefits Chart (what's covered)****Dental services (Medicare-covered)**

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.

\*This is not a guarantee of coverage.

\*Certain procedures subject to prior authorization. Your dentist will submit documentation such as x-rays and a narrative to support the procedures are medically necessary and meet acceptable clinical guidelines.

There is no coinsurance, copayment, or deductible for members eligible for these services.

**Prior authorization may be required for comprehensive dental.**

**Dental services (Supplemental)\***

We have established a partnership with a vendor to provide comprehensive dental coverage that aligns with the services offered by New York State Medicaid. Services will be covered when they are received from an affiliated provider through our vendors network.

Your dental benefits include Diagnostic, Preventive, Restorative Services, Endodontics, Periodontics, Prosthodontics (removable), Prosthodontics (fixed), Maxillofacial Prosthetics,

**Dental services (Supplemental)\* (continued)**

Implant Services, Oral and Maxillofacial Surgery, and Adjunctive General Services.

For a complete list of services please visit [www.health.ny.gov/health\\_care/medicaid/program/dental/provider/index.htm](http://www.health.ny.gov/health_care/medicaid/program/dental/provider/index.htm) and select Updated Fee Schedule

The codes listed in the benefit schedule link above may be updated by the American Dental Association (ADA) during the year. If you have a question about a dental ADA code, please

There is no coinsurance or copayment.

Not all dental procedures recommended by a dentist may be covered. Have the dentist tell you what the plan will pay and what you will have to pay out-of-pocket.

You may be responsible for costs if a service is not covered or if you exceed your maximum allowance. Limitations and exclusions may apply.

**Chapter 4 Medical Benefits Chart (what's covered)**

call Member Services. Their phone number can be found on the back of your plan member ID card. Some dental services may require prior authorization and must be medically necessary. Your provider will handle any plan-required authorizations for you.

Note: The above coverage is for Medicare Supplemental Dental Benefit. Your New York Medicaid Dental Benefit is also administered by your Senior Whole Health Medicare Complete Care (HMO D-SNP). Please contact the Plan with any questions on this Medicaid benefit.

 **Depression screening**

We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.

There is no coinsurance, copayment, or deductible for an annual depression screening visit.

 **Diabetes screening**

We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes.

You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.

There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.

 **Diabetes self-management training, diabetic services, and supplies**

For all people who have diabetes (insulin and non-insulin users). Covered services include:

- o 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.
- o Blood glucose (sugar) monitors

There is no coinsurance, copayment, or deductible for this benefit.

Supplies are covered when you have a prescription and fill it at a network retail pharmacy or through the Mail Service Pharmacy program.

### Chapter 4 Medical Benefits Chart (what's covered)

- o Covered when your doctor prescribes for use in your home.
- o Preferred brand blood glucose monitors do not require prior authorization.
- o Blood glucose (sugar) test strips
- o Preferred brand blood glucose test strips do not require prior authorization.
- o May be limited to a 30-day supply per fill.
- o Preferred brand blood glucose monitors do not require prior authorization.
- o Glucose control solutions for checking the accuracy of test strips and monitors.
- o 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.
- Medicare-covered diabetic services include:
  - o Yearly eye exam and glaucoma tests
  - o Foot exams
  - o Medical nutrition therapy services (MNT)

See “Vision care” in this chart for doctor’s services if you need an eye exam for diabetic retinopathy or a glaucoma screening.

See “Podiatry services” in this chart if you are diabetic and need to see a doctor for a foot exam.

See “Medical nutrition therapy” in this chart if you are diabetic and need medical nutrition therapy services (MNT).

**Prior authorization may be required diabetic supplies, diabetic shoes, and inserts.**

**Prior authorization is not required for preferred manufacturer.**

**Prior authorization is not required for Medicare-covered diabetes self-management training.**

#### **Durable medical equipment (DME) and related supplies**

(For a definition of durable medical equipment, go to Chapter 12 and Chapter 3)

Covered items include, but aren’t limited to, wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.

There is no coinsurance, copayment, or deductible for this benefit.

**Prior authorization may be required.**

## Chapter 4 Medical Benefits Chart (what's covered)

We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at [SWHNY.com](http://SWHNY.com).

Generally, Senior Whole Health Medicare Complete Care (HMO D-SNP) covers any DME covered by Original Medicare from the brands and manufacturers on this list. We won't cover other brands and manufacturers unless your doctor or other provider tells us that the brand is appropriate for your medical needs. If you're new to Senior Whole Health Medicare Complete Care (HMO D-SNP) and using a brand of DME not on our list, we'll continue to cover this brand for you for up to 90 days. During this time, you should talk with your doctor to decide what brand is medically appropriate after this 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.)

If you (or your provider) don't agree with our plan's coverage decision, you or your provider can file an appeal. You can also file an appeal if you don't agree with your provider's decision about what product or brand is appropriate for your medical condition. (For more information about appeals, go to Chapter 9)

### 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're a pregnant woman, loss of an unborn child), loss of a

There is no coinsurance, copayment, or deductible for these services.

If you are admitted to a hospital, you will pay cost-sharing as described in "Inpatient hospital care" in this chart.

Your cost-share is the same for in-network or out-of-

**Chapter 4 Medical Benefits Chart (what's covered)**

limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network.

Emergency care outside of the United States (U.S.) may be covered under the worldwide emergency coverage benefit. We offer up to \$10,000 of worldwide emergency coverage each calendar year for emergency care, and post-stabilization care. See "Worldwide emergency care coverage" in this chart to learn more.

network emergency services.

If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered *OR* you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the highest cost sharing you would pay at a network hospital.

**Fitness benefit (Supplemental)\***

You get a fitness center membership to participating fitness centers. If you are unable to visit a fitness center or prefer to also work out from home, you can select a Home Fitness kit. The kit will help you keep active in the comfort of your home. Home Fitness options include choice of fitness tracker, strength or yoga kits.

If you choose to work out at a fitness center, you can view the website and select a participating location, or you can go directly to a participating fitness center to get started.

Participating facilities and fitness chains may vary by location and are subject to change. Kits are subject to change.

There is no coinsurance, copayment, or deductible for this benefit.

Always talk to your doctor before starting or changing your exercise routine.

** Health and wellness education programs**

We have programs available to help you manage a diagnosed health condition. Programs include:

There is no coinsurance, copayment, or deductible for these services.

**Chapter 4 Medical Benefits Chart (what's covered)**

- Asthma management
- Depression management
- Diabetes management
- High blood pressure management
- Cardiovascular Disease (CVD) management
- Chronic Obstructive Pulmonary Disease (COPD) management

Learning materials and care tips are available. We can also help you work with your provider.

Enrollment in Health Management Programs:

- You are automatically enrolled into the program(s) that best meets your needs based on medical or pharmacy claims data.
- You can also enroll through your provider or self-refer.

There are certain requirements that you must meet to enroll.

Disenrollment from Health Management Programs:

- These programs are voluntary, and you can choose to be removed from a program at any time.

You can learn more or enroll in any of the programs above by calling our Health Management Department at (866) 891-2320 (TTY: 711), Monday to Friday, 8 a.m. to 8 p.m. (Eastern Standard Time).

**Health Promotion Programs**

Other programs designed to enrich your health and lifestyle are also available, such as:

- A smoking cessation program.
- A weight control program.

For information and/or materials for smoking cessation or weight control call (866) 472-9483 (TTY/TDD: 711), Monday to Friday, 8 a.m. to 8 p.m. (Eastern Standard Time).

**Nurse Advice Line**

**Chapter 4 Medical Benefits Chart (what's covered)**

Whether you have an immediate health concern, questions about a medical condition, or would like general information about available health resources the nurse advice line is available 24 hours a day, 7 days a week.

A registered nurse will help you determine if you can manage your care at home or need the attention of a medical professional.

The toll-free Nurse Advice Line phone number is:

(877) 353-0185, (TTY/TDD: 711)

Call anytime, day or night, to speak with a registered nurse about illnesses or injuries.

- No referral or prior authorization is needed

This service isn't intended for emergencies. In case of an emergency, dial 911 immediately.

**Healthy You Card**

The plan's Healthy You card may be used to pay for select supplemental plan benefits such as:

- Over-the-counter (OTC)
- Food and produce\*
- Transportation-non-emergency (Supplemental services)

\*Chronic Conditions Eligibility requirements

The preloaded debit card is not a credit card. You cannot convert the card to cash or loan it to other people. Cosmetic procedures are not covered under this benefit card. Funds are loaded onto the card monthly. At the end of each month, any unused allocated money will not carry over to the following month or the following year. If you leave the plan any unused allocated funds revert to the plan upon your effective disenrollment date.

For more information on how to qualify for the Special Supplemental Benefits for Chronic Illnesses Food and Produce

There is no coinsurance, copayment, or deductible for your Healthy You card.

## Chapter 4 Medical Benefits Chart (what's covered)

benefit, please call Senior Whole Health Medicare Complete Care (HMO D-SNP) Member Services. To access allowances for SSBCI's, members must have a qualifying chronic condition; and provide physician approval in conjunction with Senior Whole Health Medicare Complete Care (HMO D-SNP) Case Management. Refer to "Special Supplemental Benefits for the Chronically Ill" in this chart for more information.

### Hearing services

Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.

Medicare-covered diagnostic hearing and balance exams help determine whether or not you need medical treatment.

The exam is based on a medical need only, such as a loss of hearing due to illness, disease, injury, or surgery.

### Hearing services (Supplemental) \*

In addition to the Medicare-covered hearing services, you can get a routine hearing test once every calendar year. After the routine hearing test, you may be fitted for a hearing aid.

To find an in-network hearing provider close to you can:

1. Call our Member Services Department, or
2. Search online – using our supplemental hearing provider online search tool at [MolinaHealthcare.com/Medicare](https://MolinaHealthcare.com/Medicare).

Fitting / evaluation for hearing aids can be done once every calendar year.

If you are told you need hearing aids, you can get up to 2 pre-selected hearing aids from a plan-approved provider every 2 years for both ears combined.

There is no coinsurance, copayment, or deductible for these services.

**Prior authorization may be required.**

 **HIV screening**

There's no coinsurance, copayment, or deductible for members eligible for

**Chapter 4 Medical Benefits Chart (what's covered)**

For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover:

- o One screening exam every 12 months.

If you are pregnant, we cover:

- o Up to 3 screening exams during a pregnancy

Medicare-covered preventive HIV screening.

**Home health agency care**

Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.

Covered services include, but aren't limited to:

- o 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)
- o Physical therapy, occupational therapy, and speech therapy
- o Medical and social services
- o Medical equipment and supplies

There is no coinsurance, copayment, or deductible for these services.

**Prior authorization may be required.**

**Home infusion therapy**

Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters).

Covered services include, but aren't limited to:

- o Professional services, including nursing services, furnished in accordance with our plan of care
- o Patient training and education not otherwise covered under the durable medical equipment benefit
- o Remote monitoring

There is no coinsurance, copayment, or deductible for these services.

**Prior authorization may be required.**

**Chapter 4 Medical Benefits Chart (what's covered)**

- o Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier

**Hospice care**

You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

- o Drugs for symptom control and pain relief
- o Short-term respite care
- o Home care

When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums.

**For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.

**For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization).

When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not Senior Whole Health Medicare Complete Care (HMO D-SNP).

## Chapter 4 Medical Benefits Chart (what's covered)

- o If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services
- o If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare

### **For services covered by Senior Whole Health Medicare Complete Care (HMO D-SNP) but not covered by Medicare**

**Part A or B:** Senior Whole Health Medicare Complete Care (HMO D-SNP) will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services.

### **For drugs that may be covered by our plan's Part D**

**benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4).

**Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

### **Immunizations**

Covered Medicare Part B services include:

- o Pneumonia vaccines
- o Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary

There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.

## Chapter 4 Medical Benefits Chart (what's covered)

- o Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B
- o COVID-19 vaccines
- o Other vaccines if you're at risk and they meet Medicare Part B coverage rules

We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information.

### Inpatient hospital care

Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day.

Covered services include but are not limited to:

- o Semi-private room (or a private room if medically necessary)
  - o Meals including special diets
  - o Regular nursing services
  - o Costs of special care units (such as intensive care or coronary care units)
  - o Drugs and medications
  - o Lab tests
  - o X-rays and other radiology services
  - o Necessary surgical and medical supplies
  - o Use of appliances, such as wheelchairs
  - o Operating and recovery room costs
  - o Physical, occupational, and speech language therapy
  - o Inpatient substance use disorder services
- Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our

You pay \$0 for days 1-90 of a hospital stay per benefit period.

Our plan covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days per benefit period, you can use these extra 60 days, your inpatient hospital coverage will be limited to 90 days per benefit period.

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'd pay at a network hospital.

**Prior authorization may be required.**

**Chapter 4 Medical Benefits Chart (what's covered)**

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 Senior Whole Health Medicare Complete Care (HMO D-SNP) provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. Senior Whole Health Medicare Complete Care (HMO D-SNP) the *specifics of* transplant related medical care, with a daily maximum of up to \$150 per day. In addition, mileage reimbursement can be requested at the amount equivalent to the standard mileage rates for taxpayers as described by the Internal Revenue Service (IRS) that is adjusted and notice published publicly. The maximum amount payable for all travel, lodging, meals, and mileage reimbursement is five-thousand dollars (\$5,000) per transplant in accordance with plan guidelines.

- o Blood - including storage and administration. Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint.
- o Physician services

**Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff.

Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at [www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](http://www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

## Chapter 4 Medical Benefits Chart (what's covered)

### Inpatient services in a psychiatric hospital

Covered services include mental health care services that require a hospital stay

- You can get these services either in a general hospital or a psychiatric hospital that only cares for people with mental health conditions.
- If you're in a psychiatric hospital (instead of a general hospital), Medicare only pays for up to 190 days of inpatient psychiatric hospital services during your lifetime.
- If you used part of your 190-day lifetime limit prior to enrolling in our plan, then the number of covered lifetime hospital days is reduced by the number of inpatient days for mental health care treatment previously covered by Medicare in a psychiatric hospital.
- The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.
- There's no limit to the number of benefit periods you can have when you get mental health care in a general hospital. You can also have multiple benefit periods when you get care in a psychiatric hospital, but there's a lifetime limit of 190 days.

Medicare doesn't cover:

- Private duty nursing
- A phone or television in your room
- A private room (unless medically necessary)

You pay \$0 for days 1 - 90 of a hospital stay per benefit period.

Our plan also covers 60 "lifetime reserve days." These are "extra" days that we cover. If your hospital stay is longer than 90 days per benefit period, you can use these extra days. But once you have used up these extra 60 days, your inpatient hospital coverage will be limited to 90 days per benefit period.

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.

**Prior authorization may be required.** Except in an emergency, your doctor must tell us that you are going to be admitted to the hospital.

### Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay

If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you

There is no coinsurance, copayment, or deductible for benefit.

### Chapter 4 Medical Benefits Chart (what's covered)

get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to:

- o Physician services
- o Diagnostic tests (like lab tests)
- o X-ray, radium, and isotope therapy including technician materials and services
- o Surgical dressings
- o Splints, casts, and other devices used to reduce fractures and dislocations
- o 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
- o 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
- o Physical therapy, speech therapy, and occupational therapy

**Prior authorization may be required.**

#### **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 the first year you get 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 get 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.

**Chapter 4 Medical Benefits Chart (what's covered)****Medicare Diabetes Prevention Program (MDPP)**

**MDPP services are covered for eligible people under all Medicare health plans.**

MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

There is no coinsurance, copayment, or deductible for the MDPP benefit.

**Medicare Part B drugs**

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

- Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump)
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan
- The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment.
- Clotting factors you give yourself by injection if you have hemophilia
  - Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs.

There is no coinsurance, copayment, or deductible for this benefit.

**Part B drugs may be subject to step therapy. Prior authorization may be required.**

**Chapter 4 Medical Benefits Chart (what's covered)**

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

## Chapter 4 Medical Benefits Chart (what's covered)

- End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®)
- o Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
- o Parenteral and enteral nutrition (intravenous and tube feeding)

In some cases, we require that you first try certain drugs to treat your medical condition before we will cover another drug for that same condition. For example, if Drug A and Drug B both treat the condition but Drug A costs less, you may need to try Drug A first. If Drug A doesn't work for you, we'll then cover Drug B. You can learn more about how we determine whether step therapy is needed by visiting [SWHNY.com](http://SWHNY.com).

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

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

### **Obesity screening and therapy to promote sustained weight loss**

If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.

There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

### **Opioid treatment program services**

Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services:

There is no coinsurance, copayment, or deductible for Medicare-covered outpatient opioid treatment program services.

**Chapter 4 Medical Benefits Chart (what's covered)**

- 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

**Prior authorization is not required for Medicare-covered outpatient opioid treatment program services, but may be needed if you require opioid treatment medications.**

**Outpatient diagnostic tests and therapeutic services and supplies**

Covered services include, but aren't limited to:

- X-rays
- Radiation (radium and isotope) therapy including technician materials and supplies
- Surgical supplies, such as dressings
- Splints, casts, and other devices used to reduce fractures and dislocations
- Laboratory tests
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used
- Other outpatient diagnostic tests – non-radiological diagnostic services such as EKGs, EEGs, pulmonary function tests, sleep studies, and treadmill stress tests.
- Diagnostic radiological services (both complex and non-complex) such as specialized scans, CT, SPECT, PET, MRI, MRA, nuclear studies, ultrasounds, diagnostic
- **Outpatient diagnostic tests and therapeutic services and supplies (continued)**

There is no coinsurance, copayment, or deductible for this benefit.

**Prior authorization may be required.**

## Chapter 4 Medical Benefits Chart (what's covered)

- o mammograms and interventional radiological procedures (myelogram, cystogram, angiogram, and barium studies).
  - o No authorization is required for outpatient lab services and outpatient X-ray services.

### Outpatient hospital observation

Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged.

For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.

Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at [www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf](http://www.Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf) or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

There is no coinsurance, copayment, or deductible for these services.

**Prior authorization may be required.**

### Outpatient hospital services

We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.

Covered services include, but aren't limited to:

- o Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery

There is no coinsurance or copayment for this benefit.

Outpatient hospital services are covered under other benefits in this chart. See these and other benefits when care is

## Chapter 4 Medical Benefits Chart (what's covered)

- o Laboratory and diagnostic tests billed by the hospital
- o Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it
- o X-rays and other radiology services billed by the hospital
- o Medical supplies such as splints and casts
- o Certain drugs and biologicals you can't give yourself

**Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff.

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://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

provided in an outpatient hospital setting:

“Emergency care”

“Worldwide emergency/urgent coverage”

“Outpatient diagnostic tests and therapeutic services and supplies”

“Outpatient surgery provided at hospital outpatient facilities and ambulatory surgical centers”

“Partial hospitalization”

Prior authorization may be required.

### 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.

Your Medicare outpatient mental health care coverage includes:

- One depression screening every calendar year. The screening must be done in a primary care doctor's

There is no coinsurance, copayment, or deductible for this benefit.

See “Depression screening” in this chart for your yearly depression screening.

See “Partial hospitalization” in this chart if you need this Medicare-covered outpatient mental health care treatment.

**Chapter 4 Medical Benefits Chart (what's covered)**

office or primary care clinic that can provide follow-up treatment and referrals.

- o Individual and group psychotherapy with doctors or certain licensed professionals allowed by the state where you get these services.
- o Family counseling, if the main purpose is to help with your treatment.
- o Testing to find out if you're getting the services you need and if your current treatment is helping you.
- o Psychiatric evaluation.
- o Medication management.

**Prior authorization may be required.**

**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).

There is no coinsurance, copayment, for this benefit.

Prior authorization may be required.

**Outpatient substance use disorder services**

We cover outpatient care for the treatment of drug or alcohol dependence, without the use of pharmaceutical drugs.

Services may include intensive outpatient services as well as traditional counseling.

There is no coinsurance, copayment, for this benefit.

**Prior authorization may be required.**

**Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers**

**Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit

There is no coinsurance, copayment, for this benefit.

**Chapter 4 Medical Benefits Chart (what's covered)**

you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.

**Prior authorization may be required.**

**Over-the-Counter (OTC) items (Supplemental)\***

You get \$53 every month to spend on plan-approved OTC items, products, and medications with your Healthy You card. This monthly allowance is shared with the allowance for Transportation non-emergency (Supplemental) services. You may use this allowance for OTC items, or Transportation services, or a combination of both with your Healthy You card. If you don't use all of your monthly allowance, the remaining balance will expire and not roll over to the next month.

There is no coinsurance or copayment if you are using your Healthy You card.

You may be responsible for costs if you exceed your maximum monthly allowance.

Limitations and exclusions may apply.

Your coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages.

You can order:

- Online – visit [NationsOTC.com/Molina](https://NationsOTC.com/Molina)
- By Phone – 877-208-9243 to speak with a NationsOTC Member Experience Advisor at (TTY 711), 24 hours a day, seven days a week, 365 days a year.
- By Mail – Fill out and return the order form in the product catalog.
- Through participating retail locations.

Refer to your 2026 OTC Product Catalog for a complete list of plan-approved OTC items or call an OTC support person for more information. You will find important information (order guidelines) in the 2026 OTC Product Catalog.

**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's more

There is no coinsurance, copayment, or deductible for Medicare-covered

**Chapter 4 Medical Benefits Chart (what's covered)**

intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.

*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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.

partial hospitalization services.

**Prior authorization may be required.**

**Physician/Practitioner services, including doctor's office visits**

Covered services include:

- o Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. Prior authorization may be required.
- o Consultation, diagnosis, and treatment by a specialist
- o Basic hearing and balance exams performed by your PCP if your doctor orders it to see if you need medical treatment
- o Certain telehealth services, including primary care services
- 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. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. To locate a network provider, visit our website at [SWHNY.com](http://SWHNY.com).
- o **Physician/Practitioner services, including doctor's office visits (continued)**

There is no coinsurance, copayment, or deductible for these services.

**Chapter 4 Medical Benefits Chart (what's covered)**

- Virtual medical visits are medical visits delivered to you outside of medical facilities by virtual providers that use online technology and live audio/video capabilities.
- Note: Not all medical conditions can be treated through virtual visits. The virtual visit doctor will identify if you need to see an in-person doctor for treatment.
- 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. Prior authorization may be required.
- Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location. Prior authorization may be required.
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. Prior authorization may be required.
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  - You have an in-person visit within 6 months prior to your first telehealth visit
  - You have an in-person visit every 12 months while getting these telehealth services
  - 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:**
  - You're not a new patient **and**
  - The check-in isn't related to an office visit in the past 7 days **and**
  - The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment

**Chapter 4 Medical Benefits Chart (what's covered)**

- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if**:
- You're not a new patient **and**
- The evaluation isn't related to an office visit in the past 7 days **and**
- The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your doctor has with other doctors by phone, internet, or electronic health record
- Second opinion *by another network provider* prior to surgery
- Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). Prior authorization may be required.
- Monitoring services in a physician's office or outpatient hospital setting if you are taking anti-coagulation medications, such as Coumadin, Heparin, or Warfarin.

**Podiatry services (Medicare-covered)**

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

There is no coinsurance, or copayment for this benefit.

**Prior authorization may be required.**

**Podiatry services (Supplemental) \***

There is no coinsurance or copayment for each podiatry visit.

**Chapter 4 Medical Benefits Chart (what's covered)**

You don't need an underlying condition to take advantage of this benefit.

Coverage includes general foot care such as corn and callous removal, cutting of toenails, treatment of cracked skin, and other foot problems.

Plan maximum of up to 6 supplemental routine foot care visits every calendar year.

Prior authorization may be required.

 **Pre-exposure prophylaxis (PrEP) for HIV prevention**

If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we covers pre-exposure prophylaxis (PrEP) medication and related services.

If you qualify, covered services include:

- FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug.
- Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months.
- Up to 8 HIV screenings every 12 months.

A one-time hepatitis B virus screening.

There is no coinsurance, copayment, or deductible for the PrEP benefit.

 **Prostate cancer screening exams**

For men aged 50 and older, covered services include the following once every 12 months:

- Digital rectal exam
- Prostate Specific Antigen (PSA) test

There is no coinsurance, copayment, or deductible for an annual PSA test.

**Prosthetic and orthotic devices and related supplies**

Devices (other than dental) that replace all or part of a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as colostomy bags and supplies directly

There is no coinsurance, or copayment for this benefit.

**Prior authorization may be required.**

**Chapter 4 Medical Benefits Chart (what's covered)**

related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.

**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.

There is no coinsurance, or copayment for this benefit.

**Prior authorization may be required.**

**Screening and counseling to reduce alcohol misuse**

We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent.

If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.

There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

**Screening for lung cancer with low dose computed tomography (LDCT)**

For qualified people, a LDCT is covered every 12 months.

**Eligible members are** people age 50 – 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.

There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision-making visit

**Chapter 4 Medical Benefits Chart (what's covered)**

*For LDCT lung cancer screenings after the initial LDCT screening:* the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.

**Screening for Hepatitis C Virus infection**

We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions:

- You're at high risk because you use or have used illicit injection drugs.
- You had a blood transfusion before 1992.
- You were born between 1945-1965.

If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.

There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

**Screening for sexually transmitted infections (STIs) and counseling to prevent STIs**

We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.

We also cover up to 2 people 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.

There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

**Services to treat kidney disease**

There is no coinsurance,

## Chapter 4 Medical Benefits Chart (what's covered)

Covered services include:

- o Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to 6 sessions of kidney disease education services per lifetime
- o 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)
- o Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care)
- o Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- o Home dialysis equipment and supplies
- o 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)

copayment, or deductible for these services.

Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B Drugs, go to **Medicare Part B drugs** in this table.

### Skilled nursing facility (SNF) care

(For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.)

Covered services include but aren't limited to:

- o Semiprivate room (or a private room if medically necessary)
- o Meals, including special diets
- o Skilled nursing services
- o Physical therapy, occupational therapy and speech therapy
- o Drugs administered to you as part of our plan of care (this includes substances that are

There is no coinsurance, or copayment for this benefit.

**Prior authorization may be required.**

## Chapter 4 Medical Benefits Chart (what's covered)

naturally present in the body, such as blood clotting factors.)

- o Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood you need - you must either pay the costs for the first 3 pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.
- o Medical and surgical supplies ordinarily provided by SNFs
- o Laboratory tests ordinarily provided by SNFs
- o X-rays and other radiology services ordinarily provided by SNFs
- o Use of appliances such as wheelchairs ordinarily provided by SNFs
- o Physician/Practitioner services

Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.

- o 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)
- o A SNF where your spouse or domestic partner is living at the time you leave the hospital

### **Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)**

Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria:

- Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease
- Are competent and alert during counseling
- A qualified physician or other Medicare-recognized practitioner provides counseling

There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

**Chapter 4 Medical Benefits Chart (what's covered)**

We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)

**Smoking and tobacco use cessation services (Supplemental)\***

There is no coinsurance, copayment, or deductible for these services.

If you want to quit smoking you should talk to your Primary Care Physician or call our Health Education Department.

In addition to the coverage offered under the Medicare-covered smoking and tobacco use cessation benefit, the plan covers 8 additional counseling services every calendar year to help you stop smoking or using tobacco products.

You must exhaust your Medicare-covered tobacco use cessation benefit before the plan will pay for coverage under this benefit.

**Special Supplemental Benefits for the Chronically Ill**

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.

- o Autoimmune disorders;
- o Cardiovascular disorders
- o Chronic heart failure
- o Dementia
- o Diabetes mellitus
- o Chronic lung disorders
- o Chronic kidney disease (CKD)
- o Chronic alcohol use disorder and other substance use disorders (SUDs)
- o Cancer
- o Overweight, obesity, and metabolic syndrome
- o Chronic gastrointestinal disease
- o Severe hematologic disorders
- o HIV/AIDS
- o Chronic and disabling mental health conditions

There is no coinsurance or copayment if you are using your Healthy You card.

Participation in a care management program may be required. Members must also have physician sign off for testing based on lack of historical medical information.

Prior authorization may be required.

**Chapter 4 Medical Benefits Chart (what's covered)**

- o Neurologic disorders
- o Stroke
- o Post-organ transplantation
- o Immunodeficiency and Immunosuppressive disorders
- o Conditions associated with cognitive impairment
- o Conditions with functional challenges
- o Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell
- o Conditions that require continued therapy services in order for individuals to maintain or retain functioning

We will help you with accessing these benefits. You can call Member Services or your Care Coordinator to initiate your request or get additional information.

Note: By requesting this benefit you are authorizing Senior Whole Health Medicare Complete Care (HMO D-SNP) representatives to contact you by phone, mail or any other methods of communication as expressly outlined in your application.

Upon approval, your preloaded Healthy You card will be automatically loaded to be used towards the SSBCI benefits.

**Food and Produce**

If eligible, you get \$50 each month to spend on Food and Produce benefits. Any unused funds at the end of each month will not carry over to the following month.

You can use the allowance on your preloaded debit card towards a variety of brand-name and generic healthy food products at your nearby participating local store, or online

**Chapter 4 Medical Benefits Chart (what's covered)**

with home delivery for no additional costs at NationsOTC.com/Molina.

**Supervised Exercise Therapy (SET)**

SET is covered for members who have symptomatic peripheral artery disease (PAD).

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.

There is no coinsurance, or copayment for members eligible for this benefit.

**Prior authorization may be required.**

**Transportation-non-emergency (Supplemental)\***

You have \$53 every month to spend on Transportation to a health-related location at your discretion on your Healthy You card. This amount does not correspond to a set number of "rides" but can be used to purchase non-emergency transport to the benefit limit. This amount is combined with the Over-the-counter (OTC) monthly allowance. If you don't use all of your monthly benefit amount, the remaining balance will expire and not rollover to the next month.

There is no coinsurance or copayment for these services if you are using your Healthy You card.

You may be responsible for costs if you exceed your maximum annual allowance.

Limitations and exclusions may apply.

## Chapter 4 Medical Benefits Chart (what's covered)

You may use your preloaded Healthy You card to purchase rides on ride-hailing applications, on taxi services, or towards other forms of non-emergency transport, such as bus passes, rail cards, or other forms of public transit. Members are encouraged to maximize the number of rides available through this allowance. For commonly requested destinations, like dialysis centers or physical therapy facilities, contact the providing facility directly to see if more economical transportation is available before scheduling through a ride-hailing or retail transportation service.

### Urgently needed services

A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

There is no coinsurance or copayment for this benefit.



### Vision care (Medicare-covered)

Covered services include:

- o 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.
- o For people who are at high risk for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African Americans who are age 50

There is no coinsurance or copayment for members eligible for this benefit.

**Prior authorization may be required for eyewear.**

**Chapter 4 Medical Benefits Chart (what's covered)**

and older and Hispanic Americans who are 65 or older.

- o For people with diabetes, screening for diabetic retinopathy is covered once per year
- o One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.

**Vision care (Supplemental) \***

There is no coinsurance or copayment for members eligible for this benefit.

We have partnered with a Vision Vendor to give you more value for your routine vision needs!

Supplemental Vision services covered include, but not limited to:

Coverage includes:

- One routine eye exam every calendar year
- An eyewear allowance

You can use your \$350 eyewear allowance to purchase:

- Contact lenses\*
- Eyeglasses (lenses and frames)
- Eyeglass lenses and / or frames
- Upgrades (such as, tinted, U-V, polarized or photochromatic lenses)

\*If you choose contact lenses, your eyewear allowance can also be used to pay down all or a portion of your contact lens fitting fee. You are responsible for paying for any corrective eyewear over the limit of the plan's eyewear allowance.

\$0 copay for up to one routine eye exam (and refraction) for eyeglasses every calendar year.

**Chapter 4 Medical Benefits Chart (what's covered)**

There is no coinsurance or copayment for this benefit.

 **Welcome to Medicare preventive visit**

Our 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 preventive services you need (including certain screenings and shots), and referrals for other care if needed.

- o 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 want to schedule your *Welcome to Medicare* preventive visit.

There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

**Worldwide emergency coverage (Supplemental)\***

As an added benefit, your coverage includes up to \$10,000 every calendar year for worldwide emergent care outside of the United States (U.S.)

This benefit is limited to services that would be classified as emergency care had the care been provided in the U.S. Worldwide coverage includes emergency care, and post-stabilization care.

When these situations happen, we ask that you or someone caring for you call us. We will try to arrange for network providers to take over your care as soon as your medical condition and circumstances allow.

Transportation back to the U.S. from another country is not covered. Routine care and pre-scheduled or elective procedures are not covered.

Foreign taxes and fees (including but not limited to, currency conversion or transaction fees) are not covered.

U.S. means 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Island, and American Samoa.

There is no coinsurance, copayment, or deductible for this benefit.

If you receive emergency care outside the U.S. and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by the plan.

Your cost is the cost-sharing you would pay at a network hospital. Plan maximum applies.

You may need to file a claim for reimbursement

**Chapter 4 Medical Benefits Chart (what's covered)**

	<p>of emergency/urgent care received outside the U.S.</p> <p>Plan maximum of \$10,000 every calendar year applies for this benefit.</p>
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**SECTION 3 Services covered outside of Senior Whole Health Medicare Complete Care (HMO D-SNP)**

The following services aren't covered by **Senior Whole Health Medicare Complete Care (HMO-D-SNP)** but are available through Medicaid:

Please note that if you receive Medicaid benefits through Senior Whole Health of New York these services may be covered by your plan instead of Medicaid fee-for-service. Please read your member handbook for more information.

- Out of network Family Planning services under the direct access provisions,
- Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit),
- Methadone Maintenance Treatment Programs,
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs,
- Office for People With Developmental Disability Services,
- Comprehensive Medicaid Case Management,
- Directly Observed Therapy (DOT) for Tuberculosis Disease,
- Full-time nursing care in your home
- Home-delivered meals
- Homemaker services include basic household help, including light housekeeping or light meal preparation.

**SECTION 4 Services that aren't covered by Senior Whole Health Medicare Complete Care (HMO D-SNP) OR Medicaid**

This section tells you what services are excluded.

**Chapter 4 Medical Benefits Chart (what's covered)**

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

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

<b>Services not covered by Medicare</b>	<b>Covered only under specific conditions</b>
<b>Cosmetic surgery or procedures</b>	<p>Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member</p> <p>Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance</p>
<p><b>Custodial care</b></p> <p>Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing</p>	Not covered under any condition
<p><b>Experimental medical and surgical procedures, equipment, and medications</b></p> <p>Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community</p>	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
<p><b>Fees charged for care by your immediate relatives or members of your household</b></p>	Not covered under any condition
<p><b>Naturopath services (uses natural or alternative treatments)</b></p>	Not covered under any condition

**Chapter 4 Medical Benefits Chart (what's covered)**

<b>Orthopedic shoes or supportive devices for the feet</b>	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with, diabetic foot disease. Orthopedic shoes may be covered under Medicaid
<b>Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television</b>	Not covered under any condition
<b>Private room in a hospital</b>	Covered only when medically necessary
<b>Reversal of sterilization procedures and or non-prescription contraceptive supplies</b>	Not covered under any condition
<b>Routine chiropractic care</b>	Manual manipulation of the spine to correct a subluxation is covered
<b>Routine foot care</b>	Some limited coverage provided according to Medicare guidelines (e.g., if you have diabetes)
<b>Services considered not reasonable and necessary, according to Original Medicare standards</b>	Not covered under any condition

# CHAPTER 5:

## Using plan coverage for Part D drugs

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### How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're 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 sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at (833) 671-0440 (TTY users call 711) and ask for the LIS Rider. (Phone numbers for Member Services are printed on the back cover of this document.)

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

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

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. For more information on Medicaid drug coverage, you should contact your State Medicaid office (the contact information is listed in Chapter 2, Section 6).

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

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

**Chapter 5 Using plan coverage for Part D drugs**

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

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

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

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

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

To find a network pharmacy, go to your *Provider/Pharmacy Directory*, visit our website ([SWHNY.com](http://SWHNY.com)), and/or call Member Services at (833)671-0440 (TTY users call 711).

You may go to any of our network pharmacies.

**If your pharmacy leaves the network**

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at (833) 671-0440 (TTY users call 711) or use the *Pharmacy Directory*. You can also find information on our website at [SWHNY.com](http://SWHNY.com).

**Specialized pharmacies**

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Member Services at (833) 671-0440 (TTY users call 711).
- 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.

## Chapter 5 Using plan coverage for Part D drugs

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- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider/Pharmacy Directory* SWHNY.com or call Member Services(833) 671-0440(TTY users call 711).

### Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. The drugs that aren't available through our plan's mail-order service are marked with as "**NM**" for No Mail Order in our Drug List.

Our plan's mail-order service allows you to order **up to a 100-day supply**.

To get order forms and information about filling your prescriptions by mail call Member Services or visit our website at [SWHNY.com](http://SWHNY.com).

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. If there is an urgent need or this timing is delayed, please call Member Services for help in receiving a temporary supply of your prescription.

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

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

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

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 14 days before your current prescription will run out. This will ensure your order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, please call Member Services or visit our website at [SWHNY.com](http://SWHNY.com).

## Chapter 5 Using plan coverage for Part D drugs

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

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

Our 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 you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* SWHNY.com tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services (833) 671-0440 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services at (833) 671-0440 (TTY users call 711)** to see if there's a network pharmacy nearby.

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

- If the prescription is related to urgently needed care
- If these prescriptions are related to care for a medical emergency
- Coverage will be limited to a 31-day supply unless the prescription is written for less.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

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

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

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

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

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. For more information on Medicaid drug coverage, you should contact your State Medicaid office (the contact information is listed in Chapter 2, Section 6).

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

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

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

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

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

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

## Chapter 5 Using plan coverage for Part D drugs

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### Over-the-counter drugs

Our plan also covers certain over-the-counter drugs. Some over-the-counter drugs are less expensive than prescription drugs and work just as well. For more information, call Member Services at (833) 671-0440 (TTY users call 711).

### Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

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

### Section 3.2 Six (6) cost-sharing Tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of six (6) cost-sharing tiers. In general, the higher the tier, the higher your cost for the drug:

- Tier 1 - Preferred Generic
- Tier 2 - Generic
- Tier 3 - Preferred Brand
- Tier 4 - Non-Preferred Drug
- Tier 5 - Specialty Tier
- Tier 6 - Select Care Drugs

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

## Chapter 5 Using plan coverage for Part D drugs

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

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

- Check the most recent Drug List we provided electronically.
- Visit the plan's website ([SWHNY.com](http://SWHNY.com)). The Drug List on the website is always the most current.
- Call Member Services (833) 671-0440 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" ([Caremark.com](http://Caremark.com) or by calling Member Services). search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member services at (833) 671-0440 (TTY users call 711).

## SECTION 4 Drugs with restrictions on coverage

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### Section 4.1 Why some drugs have restrictions

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

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

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

### Section 4.2 Types of restrictions

**If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug.** Call Member Services (833) 671-0440 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

## Chapter 5 Using plan coverage for Part D drugs

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### Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at (833) 671-0440 (TTY users call 711) or on our website *SWHNY.com*.

### Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at (833) 671-0440 (TTY users call 711) or on our website *SWHNY.com*.

### Quantity limits

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

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

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

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

**If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.**

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

- You may be able to get a temporary supply of the drug.
- You can change to another drug.

## Chapter 5 Using plan coverage for Part D drugs

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- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

### You may be able to get a temporary supply

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

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

- **If you're a new member**, we'll cover a temporary supply of your drug during the first **90 days** of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first **90 days** of the calendar year.
- This temporary supply will be for a maximum of 31-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 31 day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day supply emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- If you are a new resident of an LTC facility and have been enrolled in our plan for more than 90 days and need a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or quantity limits (dosage limits), we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the member pursues a formulary exception. Exceptions are available in situations where you experience a change in the level of care you are receiving that also requires you to transition from one facility or treatment center to another. In such circumstances, you would be eligible for a temporary, one time fill exception even if you are outside the first 90 days as a member of the plan. Please note that our transition policy applies only to those drugs that are "Part D" and bought at a network pharmacy. The transition policy cannot be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access.

For questions about a temporary supply, call Member Services (833) 671-0440711 (TTY users call 711).

**Chapter 5 Using plan coverage for Part D drugs**

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

**Option 1. You can change to another drug**

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at (833) 671-0440 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

**Option 2. You can ask for an exception**

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

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

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

**Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high**

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

**You can change to another drug**

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at (844) 239-4913. (TTY users call 711) 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.

**You can ask for an exception**

## Chapter 5 Using plan coverage for Part D drugs

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You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Tier 5 Specialty aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

### **SECTION 6 Our Drug List can change during the year**

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

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

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

#### **Information on changes to drug coverage**

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

#### **Changes to drug coverage that affect you during this plan year**

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List.**
  - We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

**Chapter 5 Using plan coverage for Part D drugs**

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- We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
- We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover an 31-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 31-day fill of the drug you take.

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

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

## Chapter 5 Using plan coverage for Part D drugs

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

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

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

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

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

### **SECTION 7    Types of drugs we don't cover**

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

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

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

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

## Chapter 5 Using plan coverage for Part D drugs

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In addition, by law, the following categories of drugs listed below aren't covered by Medicare. However, some of these drugs may be covered for you under your Medicaid drug coverage. For more information on Medicaid drug coverage, you should contact Member Services or your State Medicaid office (the contact information is listed in Chapter 2, Section 6).

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

**If you get Extra Help** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

## SECTION 8 How to fill a prescription

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

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

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

## **SECTION 9 Part D drug coverage in special situations**

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

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

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

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

Check your *Provider/Pharmacy Directory* SWHNY.com to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at (833) 671-0440 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

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

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

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

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

#### **Special note about creditable coverage:**

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

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

**Chapter 5 Using plan coverage for Part D drugs**

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

**Section 9.4 If you're in Medicare-certified hospice**

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

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

**SECTION 10 Programs on drug safety and managing medications**

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

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

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

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

**Chapter 5 Using plan coverage for Part D drugs**

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

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

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

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

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

**Section 10.2 Medication Therapy Management (MTM) program to help members manage medications**

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

**Chapter 5 Using plan coverage for Part D drugs**

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

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, please contact Member Services (833) 671-0440 (TTY users call 711).

## **CHAPTER 6:**

# **What you pay for Part D drugs**

### **SECTION 1 What you pay for Part D drugs**

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We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage (*SWHNY.com*), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the “Real-Time Benefit Tool” by calling Member Services at (833) 671-0440 (TTY users call 711).

#### **How can you get information about your drug costs if you’re getting Extra Help with your Part D prescription drug costs?**

Because you’re eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don’t have this insert, call Member Services at (833) 671-0440 (TTY users call 711) and ask for the *LIS Rider*.

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

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

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

## Chapter 6 What you pay for Part D drugs

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

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

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

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

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

#### **Moving to the Catastrophic Coverage Stage:**

When you (or those paying on your behalf) have spent a total of \$2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

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

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

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

## Chapter 6 What you pay for Part D drugs

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- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

*Reminder:* If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at (833) 671-0440 (TTY users call 711).

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### Tracking your out-of-pocket total costs

**The *Part D Explanation of Benefits (EOB)* you get includes the current total of your out-of-pocket costs. When this amount reaches \$2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.**

- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

## SECTION 2 Drug payment stages for Senior Whole Health Medicare Complete Care (HMO D-SNP) members

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

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

**Chapter 6 What you pay for Part D drugs**

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

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- Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:
- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track

## Chapter 6 What you pay for Part D drugs

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of your out-of-pocket costs, give us copies of your receipts. **Examples** of when you should give us copies of your drug receipts:

- When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
- When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
- Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.

If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Member Services (833) 671-0440 (TTY users call TTY 711).. Plan members can access their EOBs online at [Caremark.com](https://www.caremark.com). Be sure to keep these reports. Be sure to keep these reports.

### SECTION 4 The Deductible Stage

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

If you don't get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you're in this payment stage, **you must pay the full cost of your drugs** until you reach our plan's deductible amount, which is \$199 for 2026. The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of \$199 on drugs. **You must pay the full cost of your drugs** until you reach our plan's deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

**Chapter 6 What you pay for Part D drugs**

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Once you pay \$199 for your drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

**SECTION 5 The Initial Coverage Stage**

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

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

**Our plan has six (6) cost-sharing tiers**

Every drug on our plan's Drug List is in one of cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- *Tier 1 - Preferred Generic*
- *Tier 2 - Generic*
- *Tier 3 - Preferred Brand*
- *Tier 4 - Non-Preferred Drug*
- *Tier 5 - Specialty Tier*
- *Tier 6 - Select Care Drugs*

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

**Your pharmacy choices**

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

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

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

**Chapter 6 What you pay for Part D drugs****Section 5.2 Your costs for a one-month supply of a covered drug**

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

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

**Your costs for a one-month supply of a covered Part D drug**

<b>Tier</b>	<b>Standard retail in-network cost sharing (up to a 31-day supply)</b>	<b>Mail-order cost sharing (up to a 31-day supply)</b>	<b>Long-term care (LTC) cost sharing (up to a 31-day supply)</b>	<b>Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 31-day supply)</b>
<b>Cost-Sharing Tier 1 (Preferred Generic)</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay
<b>Cost-Sharing Tier 2 (Generic)</b>	\$0, \$1.60, or \$2 copay for all drugs per prescription	\$0, \$1.60, or \$2 copay for all drugs per prescription	\$0, \$1.60, or \$2 copay for all drugs per prescription	\$0, \$1.60, or \$2 copay for all drugs per prescription

**Chapter 6 What you pay for Part D drugs**

Tier	Standard retail in-network cost sharing  (up to a 31-day supply)	Mail-order cost sharing  (up to a 31-day supply)	Long-term care (LTC) cost sharing  (up to a 31-day supply)	Out-of-network cost sharing  (Coverage is limited to certain situations; go to Chapter 5 for details.)  (up to a 31-day supply)
<b>Cost-Sharing Tier 3 (Preferred Brand)</b>	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription
<b>Cost-Sharing Tier 4 (Non-Preferred Drug)</b>	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription

**Chapter 6 What you pay for Part D drugs**

<b>Tier</b>	<b>Standard retail in-network cost sharing (up to a 31-day supply)</b>	<b>Mail-order cost sharing (up to a 31-day supply)</b>	<b>Long-term care (LTC) cost sharing (up to a 31-day supply)</b>	<b>Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 31-day supply)</b>
<b>Cost-Sharing Tier 5 (Specialty)</b>	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription
<b>Cost-Sharing Tier 6 (Select Care Drugs)</b>	\$0 copay	\$0 copay	\$0 copay	\$0 copay

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

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

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

## Chapter 6 What you pay for Part D drugs

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

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

### Section 5.4 Your costs for a long-term (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

#### Your costs for a long-term supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network) (up to a 100-day supply)	Mail-order cost sharing (up to a 100 day supply)
<b>Cost-Sharing Tier 1 (Preferred Generic)</b>	\$0 copay	\$0 copay
<b>Cost-Sharing Tier 2 (Generic)</b>	\$0, \$1.60, or \$4 copay for all drugs per prescription	\$0, \$1.60, or \$4 copay for all drugs per prescription
<b>Cost-Sharing Tier 3 (Preferred Brand)</b>	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription

**Chapter 6 What you pay for Part D drugs**

<b>Tier</b>	<b>Standard retail cost sharing (in-network)</b> (up to a 100-day supply)	<b>Mail-order cost sharing</b> (up to a 100 day supply)
<b>Cost-Sharing Tier 4 (Non-Preferred Drug)</b>	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription	\$0, \$1.60, or \$5.10 copay for generic drugs (including brand drugs treated as generic) \$0, \$4.90, or \$12.65 copay for all other drugs per prescription
<b>Cost-Sharing Tier 5 (Specialty)</b>	A long-term supply is not available for drugs in Tier five (5)	Mail-order is not available for a long-term supply of drugs in Tier five (5)
<b>Cost-Sharing Tier 6 (Select Care Drugs)</b>	\$0	\$0

**Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach \$2,100**

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach \$2,100. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* that you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the \$2,100 out-of-pocket limit in a year.

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

**SECTION 6 The Catastrophic Coverage Stage**

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the \$2,100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

**Chapter 6 What you pay for Part D drugs**

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

**SECTION 7 What you pay for Part D vaccines**

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**Important message about what you pay for vaccines** – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan’s Drug List. Our plan covers most adult Part D vaccines at no cost to you. Go to our plan’s Drug List or call Member Services at (833) 671-0440 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

**2. Where you get the vaccine.**

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

**3. Who gives you the vaccine.**

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

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

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

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

**Chapter 6 What you pay for Part D drugs**

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

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

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

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance *OR* copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)
- *Situation 3:* You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance *OR* copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

**Chapter 6 What you pay for Part D drugs**

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## **CHAPTER 7:**

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

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

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

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

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

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

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

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

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

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

### 2. When a network provider sends you a bill you think you shouldn't pay

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

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

### 3. If you're retroactively enrolled in our plan

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

If you were retroactively enrolled in our plan and you paid out of pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for

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

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our share of the costs. You need to submit paperwork such as receipts and bills for us to handle the reimbursement.

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

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

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

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

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

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

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

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

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

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

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

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

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You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you've made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one (1) calendar year** of the date you got the service and/or item, or within 36 months of the date you got the drug.

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

- You don't have to use the form, but it'll help us process the information faster.
- Download a copy of the form from our website (SWHNY.com) or call Member Services (833) 671-0440 (TTY users call (TTY 711)) and ask for the form.

Mail your request for payment together with any bills or paid receipts to us at this address:

#### Medical Services reimbursements:

Senior Whole Health of New York  
Attn: Medicare Member Services  
200 Oceangate, Suite 100 Long Beach, CA 90802  
Or fax to (310) 507-6186

#### Prescription Drug reimbursements:

Molina Healthcare  
Attn: Pharmacy Department  
7050 Union Park Center, Suite 600  
Midvale, UT 84047

### SECTION 3 We'll consider your request for payment and say yes or no

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug

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

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is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

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

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

# CHAPTER 8:

## Your rights and responsibilities

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### SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at (833) 671-0440 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services by calling (833) 671-0440, Monday-Friday, 8 a.m. – 8 p.m., local time. TTY users, please call 711. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

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

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

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

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

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

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

#### **How do we protect the privacy of your health information?**

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

**Chapter 8 Your rights and responsibilities**

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

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

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

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

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

**NOTICE OF PRIVACY PRACTICES****THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice describes the privacy practices of Molina Healthcare's affiliated health plans (referred to herein as "Molina", "we" or "our"). We use and share protected health information ("PHI") about you to provide your health benefits as a Molina member. We use and share your PHI to carry out treatment, payment and health care operations. We also use and share your PHI for other reasons as allowed and required by law. We have the duty to keep your health information private and to follow the terms of this Notice. The effective date of this Notice is January 1, 2026.

PHI is health information that includes your name, member number or other identifiers, and is used or shared by us. PHI includes health information about substance use disorders and biometric information (like a voiceprint).

**Why do we use or share your PHI?**

We use or share your PHI to provide you with health care benefits. Your PHI is also used or shared for treatment, payment, and health care operations.

**For Treatment**

We may use or share your PHI to give you, or arrange for, your medical care. This treatment also includes referrals between your doctors or other health care providers. For example, we

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may share information about your health condition with a specialist. This helps the specialist talk about your treatment with your doctor.

### **For Payment**

We may use or share PHI to make decisions on payment. This may include claims, approvals for treatment, and decisions about medical need. Your name, your condition, your treatment, and supplies given may be written on the bill. For example, we may let a doctor know that you have our benefits. We would also tell the doctor the amount of the bill that we would pay.

### **For Health Care Operations**

We may use or share PHI about you to run our health plan(s). For example, we may use information from your claim to let you know about a health program that could help you. We may also use or share your PHI to solve your concerns. Your PHI may also be used to see that claims are paid right.

### **Health care operations involve many daily business needs. It includes but is not limited to, the following:**

- Improving quality;
- Actions in health programs to help members with certain conditions (such as asthma);
- Conducting or arranging for medical review;
- Legal services, including fraud and abuse detection and prosecution programs;
- Actions to help us obey laws;
- Addressing member needs, including solving complaints and grievances.

We will share your PHI with other companies (“business associates”) that perform different kinds of activities for our health plan(s). We may also use your PHI to give you reminders about your appointments. We may use your PHI to give you information about other treatment(s), or other health-related benefits and services.

### **When can we use or share your PHI without getting written authorization (approval) from you?**

In addition to treatment, payment and health care operations, the law allows or requires Molina to use and share your PHI for several other purposes including the following:

#### **Required by law**

We will use or share information about you as required by law. We will share your PHI when required by the Secretary of the Department of Health and Human Services (HHS). This may be for a court case, other legal review, or when required for law enforcement purposes.

#### **Public Health**

Your PHI may be used or shared for public health activities. This may include helping public health agencies to prevent or control disease.

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**Health Care Oversight**

Your PHI may be used or shared with government agencies. They may need your PHI for audits.

**Research**

Your PHI may be used or shared for research in certain cases, such as when approved by a privacy or institutional review board.

**Legal or Administrative Proceedings**

Your PHI may be used or shared for legal proceedings, such as in response to a court order.  
Law Enforcement

Your PHI may be used or shared with police for law enforcement purposes, such as to help find a suspect, witness or missing person.

**Health and Safety**

Your PHI may be shared to prevent a serious and imminent threat to the health or safety of a person or the public.

**Government Functions**

Your PHI may be shared with the government for special functions. An example would be to protect the President.

Victims of Abuse, Neglect or Domestic Violence

Your PHI may be shared with legal authorities if we believe that a person is a victim of abuse or neglect.

**Workers' Compensation**

Your PHI may be used or shared to obey Workers' Compensation laws.

**Other Disclosures**

Your PHI may be shared with funeral directors or coroners to help them do their jobs.

**Additional Restrictions on Use and Disclosure.**

Some federal and state laws may require special privacy protections that restrict the use and disclosure of certain types of health information. Such laws may protect the following types of information: alcohol and substance use disorders, biometric information, child or adult abuse or neglect including sexual assault, communicable diseases, genetic information, HIV/AIDS, mental health, minors' information, prescriptions, reproductive health, and sexually transmitted diseases. We will follow the more stringent law, where it applies to us.

Substance Use Disorder (SUD) Information. Although we are not a substance use disorder treatment program under federal law (a "SUD Program"), we may receive information from a

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SUD Program about you. We may not disclose SUD information for use in a civil, criminal, administrative, or legislative proceeding against you unless we have (i) your written consent, or (ii) a court order accompanied by a subpoena or other legal requirement compelling disclosure issued after we and you were given notice and an opportunity to be heard.

When do we need your written authorization (approval) to use or share your PHI?

We need your written approval to use or share your PHI for a purpose other than those listed in this Notice. We need your authorization before we disclose your PHI for the following: (1) most uses and disclosures of psychotherapy notes; (2) uses and disclosures for marketing purposes; and (3) uses and disclosures that involve the sale of PHI. You may cancel a written approval that you have given us. Your cancellation will not apply to actions already taken by us because of the approval you already gave to us.

**What are your health information rights?****You have the right to:**

Request Restrictions on PHI Uses or Disclosures (Sharing of Your PHI)

You may ask us not to share your PHI to carry out treatment, payment or health care operations. You may also ask us not to share your PHI with family, friends or other persons you name who are involved in your health care. However, we are not required to agree to your request. You will need to make your request in writing. You may use our form to make your request.

**Request Confidential Communications of PHI**

You may ask Molina to give you your PHI in a certain way or at a certain place to help keep your PHI private. We will follow reasonable requests, if you tell us how sharing all or a part of that PHI could put your life at risk. You will need to make your request in writing. You may use our form to make your request.

**Review and Copy Your PHI**

You have a right to review and get a copy of your PHI held by us. This may include records used in making coverage, claims and other decisions about you as our member. You will need to make your request in writing. You may use our form to make your request. We may charge you a reasonable fee for copying and mailing the records. In certain cases, we may deny the request. Important Note: We do not have complete copies of your medical records. If you want to look at, get a copy of, or change your medical records, please contact your doctor or clinic.

**Amend Your PHI**

You may ask that we amend (change) your PHI. This involves only those records kept by us about you as a member. You will need to make your request in writing. You may use our form to make your request. You may file a letter disagreeing with us if we deny the request.

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**Receive an Accounting of PHI Disclosures (Sharing of Your PHI)**

You may ask that we give you a list of certain parties that we shared your PHI with during the six years prior to the date of your request. The list will not include PHI shared as follows:

**for treatment, payment or health care operations;**

- to persons about their own PHI;
- sharing done with your authorization;
- incident to a use or disclosure otherwise permitted or required under applicable law;
- PHI released in the interest of national security or for intelligence purposes; or
- as part of a limited data set in accordance with applicable law.

We will charge a reasonable fee for each list if you ask for this list more than once in a 12-month period. You will need to make your request in writing. You may use our form to make your request.

You may make any of the requests listed above, or may get a paper copy of this Notice. Please call our Member Services department at the toll-free number on the back of your ID card, 7 days a week, 8 a.m. to 8 p.m., local time. TTY/ TDD users, please call 711.

What can you do if your rights have not been protected?

You may complain to us and to the Department of Health and Human Services if you believe your privacy rights have been violated. We will not do anything against you for filing a complaint. Your care and benefits will not change in any way.

**You may file a complaint with us at:**

Call Member Services at the toll-free number on the back of your ID card, 7 days a week, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711. Or write to us at:

Molina Healthcare  
Attn: Appeals and Grievances  
P.O. Box 22816  
Long Beach, CA 90801-9977

**You may file a complaint with the Secretary of the U.S. Department of Health and Human Services at:**

U.S. Department of Health & Human Services Office for Civil Rights  
200 Independence Ave., S.W. Suite 509F, HHH Building Washington, D.C. 20201  
(800) 368-1019; (800) 537-7697 (TDD); (202) 619-3818 (FAX)

## **What are our duties?**

### **We are required to:**

#### **Keep your PHI private;**

Give you written information such as this on our duties and privacy practices about your PHI;  
Provide you with a notice in the event of any breach of your unsecured PHI;  
Not use or disclose your genetic information for underwriting purposes;  
Follow the terms of this Notice.

#### **This Notice is Subject to Change**

We reserve the right to change its information practices and terms of this Notice at any time. If we do, the new terms and practices will then apply to all PHI we keep. If we make any material changes, we will post the revised Notice on our website and send the revised Notice, or information about the material change and how to obtain the revised Notice, in our next annual mailing to our members then covered by us. This Notice is available on our website at [www.molinahealthcare.com](http://www.molinahealthcare.com).

#### **Contact Information**

If you have any questions about this Notice, please contact us.

Call our Member Services department at the toll-free number on the back of your ID card; 7 days a week, 8 a.m. to 8 p.m., local time. TTY/TDD users, please call 711. Or write to Molina Member Services, 200 Oceangate, Suite 100, Long Beach, CA 90802.

You can get this document for free in other formats, such as large print, braille, or audio. Call (855) 882-3901, TTY/TDD: 711, 7 days a week, 8 a.m. to 8 p.m., local time. The call is free.

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

As a member of Senior Whole Health Medicare Complete Care (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services (833) 671-0440 (TTY users call 711):

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

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

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

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

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

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

## **You have the right to give instructions about what's to be done if you can't make medical decisions for yourself**

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

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

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

### **How to set up an advance directive to give instructions:**

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at (833) 671-0440 (TTY users call 711) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

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

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

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### If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with the New York State Department of Health Complaint Hotline at 1-800-206-8125 (TTY 711).

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

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

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

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

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

- **Call our plan's Member Services at (833) 671-0440 (TTY users call 711)**
- **Call your local SHIP** at SHIP. Contact information is available in Chapter 2, Section 3.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

### Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at (833) 671-0440 (TTY users call 711)**
- **Call your local SHIP** at SHIP. Contact information is available in Chapter 2, Section 3.
- **Contact Medicare**
  - Visit [www.Medicare.gov](http://www.Medicare.gov) to read the publication *Medicare Rights & Protections* (available at: [Medicare Rights & Protections](#))
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

## **SECTION 2     Your responsibilities as a member of our plan**

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Things you need to do as a member of our plan are listed below. For questions, call Member Services at (833) 671-0440 (TTY users call 711).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must continue to pay your Medicare premiums to stay a member of our plan.
  - 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* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

# CHAPTER 9:

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

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

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This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on 2 things:

1. Whether your problem is about benefits covered by **Medicare** or **Medicaid**. If you'd like help deciding whether to use the Medicare process or the Medicaid process, or both, call Member Services (833) 671-0440 (TTY users call 711).
2. The type of problem you're having:
  - For some problems, you need to use the **process for coverage decisions and appeals**.
  - For other problems, you need to use the **process for making complaints** (also called grievances).

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

The information in this chapter will help you identify the right process to use and what to do.

#### Section 1.1 Legal terms

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

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

### SECTION 2 Where to get more information and personalized help

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We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at

(833) 671-0440 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

### **State Health Insurance Assistance Program (SHIP).**

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

The services of SHIP counselors are free. SHIP contact information is available in Chapter 2, Section 3.

### **Medicare**

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- You visit [www.Medicare.gov](http://www.Medicare.gov).

### **You can get help and information from Medicaid**

- You can call the Medicaid Helpline at 1-800-541-2831 (TTY 711) Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM.
- You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: [www.health.ny.gov/health\\_care/medicaid/ldss](http://www.health.ny.gov/health_care/medicaid/ldss)
- You can also visit the New York State Medicaid website: [www.health.ny.gov/health\\_care/medicaid](http://www.health.ny.gov/health_care/medicaid)

## **SECTION 3 Which process to use for your problem**

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Because you have Medicare and get help from Medicaid, you have different processes you can use to handle your problem or complaint. Which process you use depends on if the problem is about Medicare benefits or Medicaid benefits. If your problem is about a benefit covered by Medicare, use the Medicare process. If your problem is about a benefit covered by Medicaid, use the Medicaid process. If you'd like help deciding whether to use the Medicare process or the Medicaid process, call Member Services at (833) 671-0440 (TTY users call 711).

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

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**Is your problem about Medicare benefits or Medicaid benefits?**

My problem is about **Medicare** benefits.

Go to **Section 4, Handling problems about your Medicare benefits.**

My problem is about **Medicaid** coverage.

Go to **Section 12, Handling problems about your Medicaid benefits.**

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**SECTION 4 Handling problems about your Medicare benefits**

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**Is your problem or concern about your benefits or coverage?**

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

**Yes.**

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

**No.**

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

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**Coverage decisions and appeals**

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**SECTION 5 A guide to coverage decisions and appeals**

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

## **Asking for coverage decisions before you get services**

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

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

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

## **Making an appeal**

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

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

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

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

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

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

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

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

- **Call Member Services at** (833) 671-0440 (TTY users call 711)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services and ask for the *Appointment of Representative* form (The form is also available at [www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf)).
  - For medical care, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at (833) 671-0440 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at [www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](http://www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf).) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.

- We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

## **Section 5.2 Rules and deadlines for different situations**

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

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

If you're not sure which information applies to you, call Member Services at (833) 671-0440 (TTY users call 711). You can also get help or information from your SHIP.

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

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

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

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

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

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

## **Section 6.2 How to ask for a coverage decision**

### **Legal Terms:**

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

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

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

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

**If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision.**

**If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.

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

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

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

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

***For standard coverage decisions we use the standard deadlines.***

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

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

***For fast coverage decisions we use an expedited timeframe.***

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

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

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

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

### **Section 6.3 How to make a Level 1 appeal**

#### **Legal Terms:**

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

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

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

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

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

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

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

- **You can ask for a copy of the information regarding your medical decision. 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 a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

### ***Deadlines for a fast appeal***

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

### ***Deadlines for a standard appeal***

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 11 for information on complaints.)

- If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

## Section 6.4 The Level 2 appeal process

### Legal Term:

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

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

### Step 1: The independent review organization reviews your appeal.

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

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

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

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal

**within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.

- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug.

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

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

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

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

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

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

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

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

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care isn't covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

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

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

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes

at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days.

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

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

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

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

### **Part D coverage decisions and appeals**

#### **Legal Term:**

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

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

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 7.2**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get) **Ask for an exception. Section 7.2**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier **Ask for an exception. Section 7.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4**

- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4**

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

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

## **Section 7.2 Asking for an exception**

### **Legal Terms:**

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

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

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

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

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

- 1. Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in Tier 5 Specialty. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
- 2. Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.
- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six (6) cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
  - If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
  - If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition.

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- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

### Section 7.3 Important things to know about asking for exceptions

#### Your doctor must tell us the medical reasons

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

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're requesting and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

#### We can say yes or no to your request

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

### Section 7.4 How to ask for a coverage decision, including an exception

#### Legal term:

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

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

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

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

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

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

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

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

- **If you're asking for an exception, provide the supporting statement**, which is the medical 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 get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we 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 asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

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

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're 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 asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

**Section 7.5 How to make a Level 1 appeal**

**Legal Terms:**

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

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

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

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

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4 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 the number on the back of your member ID card.** Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website SWHNY.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from

contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

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

### ***Deadlines for a fast appeal***

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

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

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request 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 asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

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

- We must give you our answer **within 14 calendar days** after we get your request.

- If we don't meet this deadline, we are required to send your request 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 asked for**, we're also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

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

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

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

**Legal Term**

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

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

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

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

- You have a right to give the independent review organization additional information to support your appeal.

### **Step 2: The independent review organization reviews your appeal.**

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

#### ***Deadlines for fast appeal***

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

#### ***Deadlines for standard appeal***

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

### **Step 3: The independent review organization gives you its answer.**

#### ***For fast appeals:***

- **If the independent review organization says yes to part or all of what you asked for**, we must **provide the drug coverage** that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

#### ***For standard appeals:***

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

### **What if the independent review organization says no to your appeal?**

**If the independent review organization says no to part or all of your appeal**, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

### **Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go 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 explains the Level 3, 4, and 5 appeals process.

## **SECTION 8     How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon**

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When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered.

## Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at (833) 671-0440 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

### 1. Read this notice carefully and ask questions if you don't understand it. It tells you:

- Your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay.
- Where to report any concerns you have about quality of your hospital care.
- Your right to **ask for an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.

### 2. You'll be asked to sign the written notice to show that you got it and understand your rights.

- You or someone who is acting on your behalf will be asked to sign the notice.
- Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

### 3. Keep your copy of the notice so you'll have the information about making an appeal (or reporting a concern about quality of care) if you need it.

- If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
- To look at a copy of this notice in advance, call Member Services at (833) 671-0440 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at [www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

## Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at (833) 671-0440 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. *Insert SHIP name and contact information.* SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

**Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.**

***How can you contact this organization?***

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

***Act quickly:***

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge**.
  - **If you meet this deadline,** you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your

planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at (833) 671-0440 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at [www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im](http://www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im).

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

**Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.**

***What happens if the answer is yes?***

- If the independent review organization says **yes**, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

***What happens if the answer is no?***

- If the independent review organization says **no**, they're saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the independent review organization says **no** to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

**Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.**

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to **Level 2** of the appeals process.

**Section 8.3 How to make a Level 2 appeal to change your hospital discharge date**

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

**Step 1: Contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended.

**Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

**Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you it's decision.**

***If the independent review organization says yes:***

- **We must reimburse you** for our share of the costs of hospital care you got since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

***If the independent review organization says no:***

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

**Step 4: If the answer is no, you need to decide whether you want to take your appeal further by going to Level 3.**

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

**SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon**

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When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying for your care.*

If you think we're ending the coverage of your care too soon, **you can appeal our decision.** This section tells you how to ask for an appeal.

**Section 9.1 We'll tell you in advance when your coverage will be ending**

**Legal Term:**

**Notice of Medicare Non-Coverage.** It tells you how you can ask for a **fast-track appeal.** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - The date when we'll stop covering the care for you.
  - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.** Signing the notice shows *only* that you got the

information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

## **Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time**

If you want to ask us to cover your care for a longer period of time, you'll need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at (833) 671-0440 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

**During a Level 1 appeal, the Quality Improvement Organization reviews your appeal.** It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

**Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.**

### ***How can you contact this organization?***

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.)

### ***Act quickly:***

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

**Step 2: The Quality Improvement Organization conducts an independent review of your case.**

**Legal Term:**

**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

***What happens during this review?***

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

**Step 3: Within one full day after they have all the information they need; the reviewers will tell you it's decision.**

***What happens if the reviewers say yes?***

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered service for as long as it's medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). There may be limitations on your covered services.

***What happens if the reviewers say no?***

- If the reviewers say *no*, then **your coverage will end on the date we told you.**
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, **you'll have to pay the full cost** of this care yourself.

**Step 4: If the answer to your Level 1 appeal is no, you decide if you want to make another appeal.**

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

### **Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time**

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

#### **Step 1: Contact the Quality Improvement Organization again and ask for another review.**

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 appeal. You could ask for this review only if you continued getting care after the date your coverage for the care ended.

#### **Step 2: The Quality Improvement Organization does a second review of your situation.**

- Reviewers at the Quality Improvement Organization will take another careful look at all the information related to your appeal.

#### **Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide on your appeal and tell you it's decision.**

#### ***What happens if the independent review organization says yes?***

- **We must reimburse you** for our share of the costs of care you got since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it's medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

#### ***What happens if the independent review organization says no?***

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

**Step 4: If the answer is no, you'll need to decide whether you want to take your appeal further.**

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

## **SECTION 10 Taking your appeal to Levels 3, 4 and 5**

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### **Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests**

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

#### **Level 3 appeal**

An **Administrative Law Judge or an attorney adjudicator** who works for the federal government will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**

- If you decide to accept the decision that turns down your appeal, the appeals process is over.
- If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

### **Level 4 appeal**

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that's favorable to you. We'll decide whether to appeal this decision to Level 5.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
  - If we decide to appeal the decision, we'll let you know in writing.
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

### **Level 5 appeal**

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## **Section 10.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests**

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The

written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

### **Level 3 appeal**

**An Administrative Law Judge or an attorney adjudicator** who works for the federal government will review your appeal and give you an answer.

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process may or may not be over.**
  1. If you decide to accept this decision that turns down your appeal, the appeals process is over.
  2. If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

### **Level 4 appeal**

The **Medicare Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

1. **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
2. **If the answer is no or if the Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

### **Level 5 appeal**

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

## Making complaints

### SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

#### Section 11.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
<b>Quality of your medical care</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the quality of the care you got (including care in the hospital)?</li> </ul>
<b>Respecting your privacy</b>	<ul style="list-style-type: none"> <li>• Did someone not respect your right to privacy or share confidential information?</li> </ul>
<b>Disrespect, poor customer service, or other negative behaviors</b>	<ul style="list-style-type: none"> <li>• Has someone been rude or disrespectful to you?</li> <li>• Are you unhappy with our Member Services?</li> <li>• Do you feel you're being encouraged to leave our plan?</li> </ul>
<b>Waiting times</b>	<ul style="list-style-type: none"> <li>• Are you having trouble getting an appointment, or waiting too long to get it?</li> <li>• Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan?                             <ul style="list-style-type: none"> <li>○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.</li> </ul> </li> </ul>
<b>Cleanliness</b>	<ul style="list-style-type: none"> <li>• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?</li> </ul>
<b>Information you get from us</b>	<ul style="list-style-type: none"> <li>• Did we fail to give you a required notice?</li> <li>• Is our written information hard to understand?</li> </ul>
<b>Timeliness</b> (These types of complaints are all about the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> <li>• You asked us for a <i>fast coverage decision</i> or a <i>fast appeal</i>, and we said no; you can make a complaint.</li> <li>• You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint.</li> </ul>

Complaint	Example
	<ul style="list-style-type: none"><li>• You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint.</li><li>• You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.</li></ul>

## Section 11.2 How to make a complaint

### Legal Terms:

A **complaint** is also called a **grievance**.

**Making a complaint** is called **filing a grievance**.

**Using the process for complaints** is called **using the process for filing a grievance**.

A **fast complaint** is called an **expedited grievance**.

### Step 1: Contact us promptly – either by phone or in writing.

- **Calling Member Services at (833) 671-0440 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
- We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Member Grievance Process.
  - You, or your authorized representative, are entitled to file an expedited grievance whenever Senior Whole Health Medicare Complete Care (HMO D-SNP) takes an extension in making an organization determination or reconsideration decision, or when we refuse a request to expedite an organization determination or reconsideration. (We cannot take an extension when making a coverage decision or deciding an appeal involves a Part B or Part D drug.) Senior Whole Health Medicare Complete Care (HMO D-SNP) will respond to these expedited grievances within (24) hours after receipt.

- We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we need for additional information and the delay is in your best interest.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

**Step 2: We look into your complaint and give you our answer.**

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

**Section 11.3 You can also make complaints about quality of care to the Quality Improvement Organization**

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization.** The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

*Or*

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

**Section 11.4 You can also tell Medicare about your complaint**

You can submit a complaint about Senior Whole Health Medicare Complete Care (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to

[www.Medicare.gov/my/medicare-complaint](http://www.Medicare.gov/my/medicare-complaint). You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

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## **Problems about your Medicaid benefits**

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### **SECTION 12 Handling problems about your Medicaid benefits**

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Our plan covers your Medicare benefits. Medicaid covers healthcare services not covered by Medicare. Your Medicaid carrier covers your Medicaid benefits. Your Medicaid carrier may be a Molina Medicaid plan or the State. We will help coordinate your care with your Medicaid benefits. We can help you ask for a coverage decision, appeal, or make a complaint about your Medicaid benefits. We can help you fill out forms, find the next step in the process, and find out who to contact for more help.

**The below information is for members who have Medicaid Managed Care through Molina Healthcare only.**

#### **You can file a Plan Appeal:**

- If you think our decision about your service authorization request is wrong, you can ask us to look at your case again. This is called a Plan Appeal.
- You have 60 calendar days from the date of the Initial Adverse Determination notice to ask for a Plan Appeal.
- You can call Member Services (800) 223-7242 (TTY:711) if you need help asking for a Plan Appeal, or following the steps of the appeal process. We can help if you have any special needs like a hearing or vision impairment, or if you need translation services.
- You can ask for a Plan Appeal, or you can have someone else, like a family member, friend, doctor or lawyer, ask for you. You and that person will need to sign and date a statement saying you want that person to represent you.
- We will not treat you any differently or act badly toward you because you ask for a Plan Appeal.

#### **Aid to Continue while appealing a decision about your care:**

If we decided to reduce, suspend or stop services you are getting now, you may be able to continue the services while you wait for your Plan Appeal to be decided. You must ask for your Plan Appeal:

- Within ten days from being told that your care is changing; or
- By the date the change in services is scheduled to occur, whichever is later.

If your Plan Appeal results in another denial you may have to pay for the cost of any continued benefits that you received.

You can call, write, or visit us to ask for a Plan Appeal. When you ask for a Plan Appeal, or soon after, you will need to give us:

- Your name and address
- Enrollee number
- Service you asked for and reason(s) for appealing
- Any information that you want us to review, such as medical records, doctors' letters or other information that explains why you need the service.
- Any specific information we said we needed in the Initial Adverse Determination notice.
- To help you prepare for your Plan Appeal, you can ask to see the guidelines, medical records and other documents we used to make the Initial Adverse Determination. If your Plan Appeal is fast tracked, there may be a short time to give us information you want us to review. You can ask to see these documents or ask for a free copy by calling (800) 223-7242 (TTY: 711).

Give us your information and materials by phone, fax, mail, online, or in person.

Phone (800) 223-7242, TTY: 711

Fax (844) 879-4471

Mail: Molina Healthcare of New York, Inc.

2900 Exterior Street Suite 202

Bronx, New York 10463

Online: <https://member.molinahealthcare.com/Member/Login>

In Person:

Molina Healthcare of New York, Inc.

2900 Exterior Street Suite 202

Bronx, New York 10463

After your call, we will send you a form which is a summary of your phone Plan Appeal. If you agree with our summary, you should sign and return the form to us. You can make any needed changes before sending the form back to us.

### **External Appeals**

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

- not medically necessary;

**Chapter 10 Ending membership in our plan**

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

You can ask New York State for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for the health plan or the state. 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, clinical trial, or treatment for a rare disease.

- You do not have to pay for an External Appeal. Before you ask for an External Appeal:
- You must file a Plan Appeal and get the plan's Final Adverse Determination; or
- If you have not gotten the service, and you ask for a fast track Plan Appeal, you may ask for an expedited External Appeal at the same time.
- Your doctor will have to say an expedited External Appeal is necessary; or
- You and 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 Plan Appeal.

You have 4 months after you receive 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 Member Services at (800) 223-7242 (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, (800) 400-8882.
- Go to the Department of Financial Service's website at [www.dfs.ny.gov](http://www.dfs.ny.gov).
- Contact the health plan at (800) 223-7242 (TTY: 711).

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

- You can get a faster decision if:
- Your doctor says that a delay will cause serious harm to your health; or

**Chapter 10 Ending membership in our plan**

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- You are in the hospital after an emergency room visit and the hospital care is denied by the plan.

This is called an **expedited External Appeal**. The external appeal reviewer will decide an expedited appeal in 72 hours or less.

If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, the plan will continue to pay for your stay if:

- you ask for a fast track Internal Appeal within 24 hours; AND
- you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. Your plan will make a decision about your fast track Plan Appeal in 24 hours. The fast track External Appeal will be decided in 72 hours.

The External Appeal reviewer will tell you and the plan the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

If you ask for a Plan Appeal, and you receive a Final Adverse Determination that denies, reduces, suspends or stops your service, you can ask for a Fair Hearing. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing and an External Appeal, the decision of the fair hearing officer will be the one that counts.

**Fair Hearings**

You may ask for a fair hearing from New York State if:

- You are not happy with a decision your local Department of Social Services or the State Department of Health made about your staying or leaving Molina Healthcare.
- You are not happy with a decision we made to restrict your services. You feel the decision limits your Medicaid benefits. You have 60 calendar days from the date of the Notice of Intent to Restrict to ask for a Fair Hearing. If you ask for a Fair Hearing within 10 days of the Notice of Intent to Restrict, or by the effective date of the restriction, whichever is later, you can continue to get your services until the Fair Hearing decision. However, if you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for the decision.
- You are not happy with a decision that your doctor would not order services you wanted. You feel the doctor's decision stops or limits your Medicaid benefits. You must file a complaint with Molina Healthcare. If Molina Healthcare agrees with your doctor, you may ask for a Plan Appeal. If you receive a Final Adverse Determination, you will

**Chapter 10 Ending membership in our plan**

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have 120 calendar days from the date of the Final Adverse Determination to ask for a state Fair Hearing.

- You are not happy with a decision that we made about your care. You feel the decision limits your Medicaid benefits.
- You are not happy we decided to:
  - reduce, suspend or stop care you were getting; or
  - deny care you wanted;
  - deny payment for care you received; or
  - did not let you dispute a co-pay amount, other amount you owe or payment you made for your health care.

You must first ask for a Plan Appeal and receive a Final Adverse Determination. You will have 120 calendar days from the date of the Final Adverse Determination to ask for a Fair Hearing.

**If you asked for a Plan Appeal, and receive a Final Adverse Determination that reduces, suspends, or stops care you getting now, you can continue to get the services your doctor ordered while you wait for your Fair Hearing to be decided. You must ask for a fair hearing within 10 days from the date of the Final Adverse Determination or by the time the action takes effect, whichever is later.** However, if you choose to ask for services to be continued, and you lose your Fair Hearing, you may have to pay the cost for the services you received while waiting for a decision.

- You asked for a Plan Appeal, and the time for us to decide your Plan Appeal has expired, including any extensions. If you do not receive a response to your Plan Appeal or we do not decide in time, you can ask for a Fair Hearing.

The decision you receive from the fair hearing officer will be final.

You can use one of the following ways to request a Fair Hearing:

1. By phone – call toll-free (800) 342-3334
2. By fax – (518) 473-6735
3. By internet – [www.otda.state.ny.us/oah/forms.asp](http://www.otda.state.ny.us/oah/forms.asp)
4. By mail – NYS Office of Temporary and Disability Assistance Office of Administrative Hearings Managed Care Hearing Unit, P.O. Box 22023 Albany, New York 12201-2023
5. In person:

For non-New York City residents:

Office of Temporary and  
Disability Assistance  
Office of Administrative Hearings

**Chapter 10 Ending membership in our plan**

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40 North Pearl Street  
Albany, New York 12243

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

When you ask for a Fair Hearing about a decision Molina Healthcare made, we must send you a copy of the evidence packet. This is information we used to make our decision about your care. The plan will give this information to the hearing officer to explain our action. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get your evidence packet by the week before your hearing, you can call (800) 223-7242 (TTY: 711) to ask for it.

Remember, you may complain anytime to the New York State Department of Health by calling (800) 206-8125.

You can also contact the State Medicaid agency for help with your Medicaid benefits. Chapter 2, Section 6 of this booklet tells you how to contact the Medicaid agency.

You can also call Member Services. You can find the phone number on the back of this booklet.

# CHAPTER 10:

## Ending membership in our plan

### SECTION 1 Ending your membership in our plan

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Ending your membership in Senior Whole Health Medicare Complete Care (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs, and you'll continue to pay your cost share until your membership ends.

### SECTION 2 When can you end your membership in our plan?

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#### Section 2.1 You may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- Call your State Medicaid Office at (800) 541-2831 to learn about your Medicaid plan options
- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.

## Chapter 10 Ending membership in our plan

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- **Your membership will usually end on the first day of the month after we get 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 Open Enrollment Period

You can end your membership during the Open Enrollment Period each year. During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- The **Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage.
  - Original Medicare *with* a separate Medicare drug plan
  - Original Medicare *without* a separate Medicare drug plan.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**You get Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

### Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:

## Chapter 10 Ending membership in our plan

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- Switch to another Medicare Advantage Plan with or without drug coverage.
- Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

### Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, you may be eligible to end your membership at other times of the year. This is known as a **Special Enrollment Period**.

**You may be eligible to end your membership during a Special Enrollment Period** if any of the following situations apply to you. These are just examples. For the full list you can contact our plan, call Medicare, or visit [www.Medicare.gov](http://www.Medicare.gov).

- Usually, when you move
- If you have New York Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

**Enrollment time periods vary** depending on your situation.

**To find out if you're eligible for a Special Enrollment Period**, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan,

## Chapter 10 Ending membership in our plan

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- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

**If you get Extra Help from Medicare to pay for your drug coverage drugs:** If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

**Your membership will usually end** on the first day of the month after your request to change our plan.

**Note:** Sections 2.1 and 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

### Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at (833) 671-0440 (TTY users call 711)**
- Find the information in the *Medicare & You 2026* handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

## SECTION 3 How to end your membership in our plan

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The table below explains how you can end your membership in our plan.

To switch from our plan to:	Here's what to do:
Another Medicare health plan	Enroll in the new Medicare health plan. You'll automatically be disenrolled from Senior Whole Health Medicare Complete Care when your new plan's coverage starts.
Original Medicare <i>with</i> a separate Medicare drug plan	Enroll in the new Medicare drug plan.

	<p>You'll automatically be disenrolled from Senior Whole Health Medicare Complete Care when your new drug plan's coverage starts.</p>
<p><b>Original Medicare <i>without</i> a separate Medicare drug plan</b></p>	<p><b>Send us a written request to <i>disenroll</i>.</b> Call Member Services at (833) 671-0440 (TTY users call 711) if you need more information on how to do this.</p> <p>You can also call <b>Medicare</b> at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048.</p> <p>You'll be disenrolled from <i>Senior Whole Health Medicare Complete Care (HMO D-SNP)</i> when your coverage in Original Medicare starts.</p>

**Note:** If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your Medicaid benefits, contact New York Medicaid at (800) 505-5678, Nassau County Department of Social Services (516) 227-7474, Bronx, Kings, New York, Queens, Richmond County Human Resources Administration/Department of Social Services (718) 557-1399, Orange County Department of Social Services (845) 291-4000, Rockland County Department of Social Services (845) 364-3040 or Westchester County Department of Social Services (914) 995-3333, Monday - Friday, 8:30 a.m. – 8 p.m., Saturday 10 a.m. – 6 p.m. Ask how joining another plan or returning to Original Medicare affects how you get your Medicaid coverage.

#### **SECTION 4    Until your membership ends, you must keep getting your medical items, services and drugs through our plan**

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Until your membership Senior Whole Health Medicare Complete Care (HMO D-SNP) ends, and your new Medicare coverage starts, you must continue to get your medical items, services and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

## **SECTION 5 Senior Whole Health of New York must end our plan membership in certain situations**

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Senior Whole Health of New York must end your membership in our **plan if any of the following happen:**

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. When Senior Whole Health Medicare Complete Care (HMO D-SNP) determines you no longer meet *special* eligibility requirements you will receive a notification letter stating the reason for the possible disenrollment. You will then have 6 months (180 days) from the date of the letter to respond for reconsideration of your membership eligibility in the Plan.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services (833) 671-0440 (TTY users call 711) to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison)
- If you're no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides drug coverage
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

### **Where can you get more information?**

If you have questions or want more information on when we can end your membership, call Member Services at (833) 671-0440 (TTY users call 711)..

### **Section 5.1 We can't ask you to leave our plan for any health-related reason**

Senior Whole Health Medicare Complete Care (HMO D-SNP) is not allowed to ask you to leave our plan for any health-related reason.

### **What should you do if this happens?**

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

### **Section 5.2 You have the right to make a complaint if we end your membership in our plan**

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

# CHAPTER 11:

## Legal notices

### SECTION 1 Notice about governing law

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The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services (CMS). In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws aren't included or explained in this document.

### SECTION 2 Notice about nondiscrimination

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**We don't discriminate** based on race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare 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, 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 [www.HHS.gov/ocr/index.html](http://www.HHS.gov/ocr/index.html).

If you have a disability and need help with access to care, call Member Services at (833) 671-0440 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

### SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Senior Whole Health Medicare Complete Care (HMO D-SNP), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

## CHAPTER 12: Definitions

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**Ambulatory Surgical Center** – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

**Appeal** – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

**Benefit Period** – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's no limit to the number of benefit periods.

**Biological Product** – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

**Biosimilar** – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

**Brand Name Drug** – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

**Catastrophic Coverage Stage** – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent \$2,100 for Part D covered drugs during the covered year.

**Chapter 12 Definitions**

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**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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Copayment (or copay)** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

**Cost Sharing** – Cost sharing refers to amounts that a member has to pay when services or drugs are covered. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of six (6) 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 our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

**Covered Drugs** – The term we use to mean all the drugs covered by our plan.

**Covered Services** – The term we use to mean all the health care services and supplies that are covered by our plan.

## Chapter 12 Definitions

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**Creditable Prescription Drug Coverage** – Prescription drug coverage (for example, from an employer or union) that’s expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

**Custodial Care** – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don’t need skilled medical care or skilled nursing care. Custodial care, provided by people who don’t have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

**Daily cost-sharing rate** – A daily cost-sharing rate may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you’re required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month’s supply. Here is an example: If your copayment for a one-month supply of a drug is \$30, and a one-month’s supply in our plan is 30 days, then your daily cost-sharing rate is \$1 per day.

**Disenroll or Disenrollment** – The process of ending your membership in our plan.

**Dual Eligible Special Needs Plans (D-SNP)** – D-SNPs enroll people who are entitled to both Medicare (Title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (Title XIX). States cover some or all Medicare costs, depending on the state and the person’s eligibility.

**Dually Eligible Individual** – A person who is eligible for Medicare and Medicaid coverage.

**Durable Medical Equipment (DME)** – Certain medical equipment that’s ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

**Chapter 12 Definitions**

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**Emergency Care** – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

**Extra Help** – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

**Generic Drug** – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

**Home Health Aide** – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

**Hospice** – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

**Hospital Inpatient Stay** – A hospital stay 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.

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**Initial Coverage Stage** – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

**Initial Enrollment Period** – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

**Integrated D-SNP** – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of people eligible for both Medicare and Medicaid. These people are also known as full-benefit dually eligible people.

**Integrated Grievance** – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

**Interchangeable Biosimilar** – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

**List of Covered Drugs (formulary or Drug List)** – A list of prescription drugs covered by our plan.

**Low Income Subsidy (LIS)** – Go to Extra Help.

**Manufacturer Discount Program** – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

**Maximum Out-of-Pocket Amount** – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for our plan premiums, Medicare Part A and Part B premiums, and prescription drugs don't count toward the maximum out-of-pocket amount. If you're eligible for Medicare cost-sharing assistance under Medicaid, you aren't responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.. (**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

**Medicaid (or Medical Assistance)** – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

## Chapter 12 Definitions

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**Medically Accepted Indication** – A use of a drug that’s either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

**Medically Necessary** – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

**Medicare** – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

**Medicare Advantage Open Enrollment Period** – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug coverage**.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn’t include the extra benefits, such as vision, dental, or hearing, that a Medicare Advantage plan may offer.

**Medicare Health Plan** – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

**Medicare Drug coverage (Medicare Part D)** – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

**Chapter 12 Definitions**

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**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 isn't a Medigap policy.)

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

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

**Network Pharmacy** – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

**Network Provider – Provider** is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

**Organization Determination** – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

**Original Biological Product** – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

**Original Medicare (Traditional Medicare or Fee-for-Service Medicare)** – Original Medicare is offered by the government, and not a private health plan like Medicare 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 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

**Out-of-Network Pharmacy** – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

## Chapter 12 Definitions

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**Out-of-Network Provider or Out-of-Network Facility** – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

**Out-of-Pocket Costs** – Go to the definition for cost sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

**Out-of-Pocket Threshold** – The maximum amount you pay out of pocket for Part D drugs.

**PACE plan** – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

**Part C** – Go to Medicare Advantage (MA) plan.

**Part D** – The voluntary Medicare Prescription Drug Benefit Program.

**Part D Drugs** – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

**Part D Late Enrollment Penalty** – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

**Primary Care Provider (PCP)** – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

**Prior Authorization** – Approval in advance to get services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

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**Prosthetics and Orthotics** – Medical devices including, but not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

**Quantity Limits** – A management tool that’s designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**“Real-Time Benefit Tool”** – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

**Rehabilitation Services** – These services include inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan must disenroll you if you permanently move out of our plan’s service area.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

**Step Therapy** – A utilization tool that requires you to first try another drug to treat your medical condition before we’ll cover the drug your physician may have initially prescribed.

**Supplemental Security Income (SSI)** – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren’t the same as Social Security benefits.

**Chapter 12 Definitions**

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**Urgently Needed Services** – A plan-covered service requiring immediate medical attention that’s not an emergency is an urgently needed service if either you’re temporarily outside our plan’s service area, or it’s unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren’t considered urgently needed even if you’re outside our plan’s service area or our plan network is temporarily unavailable.

## Senior Whole Health Medicare Complete Care (HMO D-SNP) Member Services

Method	Member Services – Contact Information
<b>CALL</b>	(833) 671-0440 Calls to this number are free. Monday-Friday, 8 a.m. to 8 p.m., local time. Member Services (833) 671-0440711 also has free language interpreter services available for non-English speakers.
<b>TTY</b>	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. Monday-Friday, 8 a.m. to 8 p.m., local time.
<b>FAX</b>	(310) 507-6186
<b>WRITE</b>	Senior Whole Health of New York Attn: Member Services 15 MetroTech Center, 11th Floor Brooklyn, NY 11201
<b>WEBSITE</b>	<a href="http://SWHNY.com">SWHNY.com</a>

Health Insurance Information, Counseling and Assistance Program (HIICAP) (New York’s **SHIP**) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
<b>CALL</b>	(800) 701-0501 Monday – Friday, 8:30 a.m. to 5:00 p.m., local time.
<b>WRITE</b>	New York State Office for the Aging 2 Empire State Plaza, 5 <sup>th</sup> Floor Albany, New York 12223-1251
<b>WEBSITE</b>	<a href="https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap">https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap</a>

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