[NOTE: INSTRUCTIONS ARE PROVIDED IN SMALL CAP, DARK BLUE TEXT. ALL VARIABLE FIELDS ARE DENOTED BY HIGHLIGHTED GRAY TEXT AND BRACKETS. THESE FIELDS MUST BE POPULATED WITH PLAN-SPECIFIC INFORMATION. ADJUST SECTION NUMBERS THROUGHOUT, IF APPLICABLE]

[FOR PLAN-SPECIFIC INSTRUCTIONS, FOLLOW THESE COLOR CODES:

PPO: GREEN

HMO: YELLOW COST: BLUE]

[DISTRIBUTION NOTE:

FOR ANNUAL MAILINGS - PLANS HAVE THE OPTION OF MAILING ONE DIRECTORY TO EVERY MEMBER – OR – ONE DIRECTORY TO EVERY ADDRESS WHERE UP TO FOUR MEMBERS RESIDE.

ENROLLMENT - PLANS MUST PROVIDE A DIRECTORY TO EACH MEMBER UPON ENROLLMENT. PLEASE REFER TO THE MARKETING GUIDELINES FOR MORE DETAILED INSTRUCTIONS.]

[Name of Plan]
[HMO / Cost / PPO] Plan
Provider Directory

This directory provides a list of [Plan Name]'s plan providers.

This directory is for [PROVIDE A DESCRIPTION OF THE PLAN'S SERVICE AREA, INCLUDING A LIST OF CITIES AND TOWNS].

This directory is current as of [date of publication]. Some plan providers may have been added or removed from the list after this directory was printed. To get the most up-to-date information about [Plan Name] plan providers in your area, you can visit [Web address] or call our Customer Service Department at [phone number], [days and hours of operation]. TTY users should call [TTY number].

[CMS approval date]

[Material ID]

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Section 1 – Introduction

This directory provides a list of [Plan Name]'s plan providers. It also includes basic information about how to get your covered services with [Plan Name]. To get more detail information about your health care coverage, please see your Evidence of Coverage.

[INSERT THIS PARAGRAPH IF APPLICABLE, DEPENDING ON PLAN ARRANGEMENT: You will have to choose one of our plan providers that is listed in this directory to be your **P**rimary **C**are {**P**hysician/**P**rovider} (PCP). The term "PCP" will be used throughout this directory. Generally, you must get your health care coverage from your PCP.]

The "plan providers" listed in this directory have agreed to provide you with your health care coverage. In most cases, your health care coverage is covered under [Plan Name]. You may go to any of our plan providers listed in this directory; however some services may require a referral. If you have been going to one plan provider, you are not required to continue going to that same provider. In some cases, you may get covered services from non-plan providers.

What is the service area for [Plan Name]?

The [FOR PPOS ONLY: States or] counties [and parts of counties] in our service area are listed below. [OPTIONAL: YOU MAY INCLUDE A MAP OF THE AREA (IN ADDITION TO LISTING THE SERVICE AREA), AND MODIFY THE PRIOR SENTENCE TO REFER READERS TO THE MAP.]

[INSERT PLAN SERVICE AREA LISTING. USE COUNTY NAME ONLY IF APPROVED FOR THE ENTIRE COUNTY. FOR PARTIALLY APPROVED COUNTIES, USE COUNTY NAME PLUS ZIP CODE, (E.G., "COUNTY NAME, THE FOLLOWING ZIP CODES ONLY: {XXXXX}…")]

How do I find [Plan Name] providers in my area?

[PLANS SHOULD DESCRIBE HOW AN ENROLLEE CAN FIND A PLAN PROVIDER NEAREST HIS OR HER HOME RELATIVE TO THE ORGANIZATIONAL FORMAT USED IN THE PROVIDER DIRECTORY.]

You can also visit [Web address] or call our Customer Service Department at [phone number], [days and hours of operation]. TTY users should call [TTY number].

What if I use non-plan providers to get my covered services?

"Non-plan providers" are providers that are not part of [Plan Name]. If you use non-plan providers, you may have to pay more.

[FOR HMO: Care or services you get from non-plan providers will not be covered, except for ambulance services, emergency care, including hospital care after you are stable (known as post-stabilization),maintenance care, urgently needed care, renal dialysis (kidney), and any services which were ordered covered through an appeals process.]

[FOR COST: You may use non-plan providers. However, if you use non-plan providers for care that is not emergency care, including maintenance and hospital care after you are stable (known as post-stabilization care), urgently needed care, or renal dialysis (kidney), you will have to pay the Original Medicare Plan out-of-pocket costs (such as a copayment, coinsurance, or deductible).]

[FOR PPO: If you get a health care service from a plan provider, this is known as an "in-network" service. The plan providers who provide you health care services are called "network" providers. A health care service you get from a non-plan provider is known as an "out-of-network" service.

Medicare requires that we have enough in-network plan providers to give you covered services that are medically necessary.

You may use non-plan providers to get your covered services. Although, your out-of-pocket costs may be higher than if you use our plan providers. For emergency care, including hospital care after you are stable, and urgently needed care, your out-of pocket costs will be the same both in and out-of- network. For cost sharing information see your Evidence of Coverage.

There are special rules for out-of-network services. Certain services that we offer are not covered out-of-network. Also, you do not need to get a referral or prior authorization when you get out-of-network care from non-plan providers. However, before getting an out-of-network service, you may want to check with your plan to see if the services you are getting are covered by your plan and are medically necessary. Although you do not need to get prior authorization for certain out-of-network services, some plans may offer a lower costs if you choose to get prior authorization. For more information, see your Evidence of Coverage.]

What should I do if I have bills from non-plan providers that I think should be paid by [Plan Name]?

[FOR HMO: We cover certain health care services that you get from non-plan providers. These include care for a medical emergency, urgently needed care, renal dialysis (kidney) that you get when you are outside the plan's service area, care that has been approved in advance by {INSERT WHICHEVER IS APPROPRIATE: a plan provider / <organization name>}, and any services which were ordered covered through an appeals process. If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at {INSERT INSTRUCTIONS THAT INCLUDE A MAILING ADDRESS}. You should never pay any non-plan provider more than what the plan is allowed by Medicare. The provider has a right to get his/her fees, but does not have a right to get them from you. Ask the non-plan provider to bill us first. If you have already paid for the covered services, we will reimburse you for our share of the cost. If you get a bill for the services, you can send the bill to us for payment. We will pay your non-plan provider for our share of the bill and will let you know what, if anything, you must pay.]

[FOR COST: We cover certain health care services that you get from non-plan providers. These

include care for a medical emergency, including hospital care after you are stable (known as post-stabilization), maintenance care, urgently needed care when you are temporarily out of the service area, medically necessary renal dialysis (kidney), care that has been approved in advance by {INSERT WHICHEVER IS APPROPRIATE: a plan provider / <organization name>}, and any services which were ordered covered through an appeals process.

If a non-plan provider asks you to pay for covered services you get in these situations, please contact us at {INSERT INSTRUCTIONS THAT INCLUDE A MAILING ADDRESS}. You should never pay any non-plan provider more than what the plan is allowed by Medicare. The provider has a right to get his/her fees, but does not have a right to get them from you. Ask the non-plan provider to bill us first. If you have already paid for the covered services, we will reimburse you for our share of the cost. If you get a bill for the services, you can send the bill to us for payment. We will pay your non-plan provider for our share of the bill and will let you know what, if anything, you must pay. We may require the non-plan provider to bill the Original Medicare Plan for the services you got. We will then pay your Medicare out-of-pocket costs, such as coinsurance and deductibles. You will have to pay your copayments.]

[FOR PPOs: If a non-plan provider asks you to pay for covered services, please contact us at {INSERT INSTRUCTIONS THAT INCLUDE A MAILING ADDRESS}. You should never pay any provider more than what is allowed by Medicare. The non-plan provider has a right to get his/her fees, but does not have a right to get them from you. Ask the non-plan provider to bill us first. If you have already paid for the covered services, we will reimburse you for our share of the cost. If you get a bill for the services, you can send the bill to us for payment. We will pay your non-plan provider for our share of the bill and will let you know what, if anything, you must pay.]

Getting care when traveling or away from the plan's service area

[FOR HMO: {IF YOUR PLAN OFFERS TRAVELER BENEFITS TO MEMBERS WHO ARE OUT OF YOUR SERVICE AREA, ADAPT AND EXPAND THE FOLLOWING PARAGRAPHS AS NEEDED TO DESCRIBE THE TRAVELER BENEFITS AND RULES RELATED TO RECEIVING THE OUT-OF-AREA COVERAGE.}

If you need care when you are outside the service area, your health care coverage is {very limited/limited}. The only services we cover when you are outside our service area are care for a medical emergency, including maintenance care and hospital care after you are stable (known as post-stabilization care), urgently needed care, renal dialysis (kidney), and care that {Organization name} or a plan provider has approved in advance. For more information about medical emergency and urgently needed care, see Section 6. If you question whether a service is covered when you travel, please call Member Services at {phone number}.]

[FOR COST: {IF YOUR PLAN OFFERS TRAVELER BENEFITS TO MEMBERS WHO ARE OUT OF YOUR SERVICE AREA, ADAPT AND EXPAND THE FOLLOWING PARAGRAPHS AS NEEDED TO DESCRIBE THE TRAVELER BENEFITS AND RULES RELATED TO RECEIVING THE OUT-OF-AREA COVERAGE. IF YOU OFFER THE EXTENDED ABSENCE OPTION, YOU MUST EXPLAIN WHETHER ALL OUT- OF- AREA ROUTINE SERVICES ARE COVERED OR WHETHER (AND WHAT) RESTRICTIONS ARE PLACED ON RECEIPT OF SERVICES, E.G., PRIOR AUTHORIZATION}.

If you need care when you are outside the service area, your health care coverage is {very limited / limited}. The only services that you may get outside our service area without paying more is for a medical emergency, including hospital care when you are stable (known as post-stabilization) and maintenance care, urgently needed care, medically necessary renal dialysis (kidney), and care that {Organization Name} or a plan provider has approved in advance.

Remember, you can get care from non-plan providers. However, if you use non-plan providers for care that is not emergency care or urgently needed care, you will have to pay more. You will have to pay the Original Medicare Plan out-of-pocket costs, such as coinsurance, copayments, and deductibles. For more information about medical emergency and urgently needed care, see Section 6. If you have questions about what services are covered when you travel, please call Member Services at {phone number}.]

[FOR PPOS: {IF YOUR PLAN OFFERS TRAVELER BENEFITS TO MEMBERS WHO ARE OUT OF YOUR SERVICE AREA, ADAPT AND EXPAND THE FOLLOWING PARAGRAPHS AS NEEDED TO DESCRIBE THE TRAVELER BENEFITS AND RULES RELATED TO RECEIVING THE OUT-OF-AREA COVERAGE.}

You can get care when you are outside the service area. If you get your care outside the service area from a non-plan provider, you may have to pay more. However, you won't have to pay more for emergency or urgently needed care whether it is provided by plan or non-plan provider. For more information about medical emergency and urgently needed care, see Section 6. If you have questions about your medical costs when you travel, please call Member Services at {phone number}.]

Can the list of plan providers change?

Yes, [Plan Name] may add or remove plan providers from our provider directory. To get current information about [Plan Name] plan providers in your area, you can visit [Web address] or call our Customer Service Department at [phone number], [days and hours of operation]. TTY users should call [TTY number].

Your rights to access and participate in medical care

You have the right to get timely access to plan providers and to all services covered by the plan. Timely access means that you can get appointments and services within a reasonable period of time. You have the right to get full information from your providers when you go for medical care. You have the right to participate fully in decisions about your health care. You have the right to refuse care.

Section 2 – Choosing your Primary Care [Provider / Physician] (PCP)

What is a "PCP"?

[FOR HMO: When you become a member of {Plan Name}, you must choose a plan provider to be your PCP. Your PCP is a {ADAPT THIS LIST OF POSSIBILITIES AS NEEDED: physician, nurse practitioner, health care professional} who meets state requirements and is trained to give you basic medical care. You will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you need. In most cases, you must see your PCP to get a referral before you see any other health care provider.]

[FOR COST: When you become a member of {Plan Name}, you must choose a plan provider to be your PCP. Your PCP is a {ADAPT THIS LIST OF POSSIBILITIES AS NEEDED: physician, nurse practitioner, health care professional} who meets state requirements and is trained to give you basic medical care. You will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you need. In most cases, you must see your PCP to get a referral before you see any other health care provider.

Medicare will pay for any Medicare-covered services that you get from a non-plan provider even if you don't have prior authorization from us. However, with the exception of emergency care or urgently needed care, your deductibles and other out-of-pocket costs will be the amounts charged by the Original Medicare Plan rather than the amounts charged by {Name of Plan}.]

[FOR PPO: When you become a member of {Plan Name}, you must choose a plan provider to be your PCP. Your PCP is a {ADAPT THIS LIST OF POSSIBILITIES AS NEEDED: physician, nurse practitioner, health care professional} who meets state requirements and is trained to give you basic medical care. You will get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you need. In most cases, you must see your PCP to get a referral before you see any other health care provider.]

How do you choose a PCP?

[EXPLAIN HOW A MEMBER CHOOSES A PCP, E.G., HOW TO FIND THE RIGHT PROVIDER IN THE PROVIDER DIRECTORY, OR GETTING HELP FROM MEMBER SERVICES. IF PUBLISHING A SEPARATE PCP DIRECTORY, INCLUDE A REFERENCE DIRECTING MEMBERS TO USE THE PCP DIRECTORY TO CHOOSE THEIR PCP. THE EXPLANATION SHOULD ALSO COVER HOW THE MEMBERS COMMUNICATE THEIR CHOICE TO THE PLAN AND HOW THE PLAN RESPONDS. IT SHOULD STATE THAT MEMBERS CAN CHANGE PCPS. INCLUDE THE FOLLOWING SENTENCE IN YOUR EXPLANATION IF IT APPLIES TO THE PLAN, ADAPTING THE WORDING AS NEEDED FOR ACCURACY: "If you want to use a particular {Plan Name} specialist or hospital, you should check with your PCP to make sure they can make referrals to that specialist or hospital."] [ADD THE FOLLOWING SENTENCE IF IT APPLIES TO YOUR PLAN: "The name and office telephone number of your PCP is printed on your membership card."]

Getting care from your PCP

[FOR HMO: Generally, you see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get on your own, without seeing your PCP first. Please see Section 4 for they type of covered services you can get on your own.

Your PCP can also help you arrange or coordinate your covered services. This includes x-rays, laboratory tests, therapies, specialists, hospital admissions, and follow-up care. Your PCP also contacts other plan providers for updates about your care and/or treatment. If you need certain types of covered services or supplies, your PCP must give approval ahead of time. Your PCP must give you a referral to see a specialist. In some cases, your PCP will {also} need to get prior authorization (prior approval). Since your PCP will provide and coordinate your health care, you should have all of your past medical records sent to your new PCP's office. The law requires us to protect your privacy of medical records and personal health information. For more information about privacy, see your Evidence of Coverage.]

[FOR COST: Generally, you see your PCP first for most of your routine health care needs. If you don't, you will have to pay the Original Medicare Plan out-of-pocket costs (such as deductibles, copayments, and coinsurance). However, there are a few types of covered services you can get on your own, without contacting your PCP first. For more information, see below and Section 4.

Your PCP can help arrange or coordinate your covered services for you. This includes x-rays, laboratory tests, therapies, specialists, hospital admissions, and follow-up care. Your PCP also contacts other plan providers for updates about your care and/or treatments. In some cases, your PCP will also need to get prior authorization (prior approval) for certain covered services. If not, you will have to pay the Original Medicare Plan out-of-pocket costs (such as deductibles, copayments, and coinsurance). Since your PCP will provide and coordinate your health care, you should have all of your past medical records sent to your new PCP's office. The law requires us to protect your privacy of your medical records and personal health information. For more information about privacy, see your Evidence of Coverage.]

[FOR PPO: Generally, you see your PCP first for most of your routine health care needs. There are only a few types of covered services you can get from plan providers on your own, without contacting your PCP first. However, you do not need to get a referral from your PCP when you get care from non-plan providers.

Your PCP can help arrange or coordinate your covered services. This includes x-rays, laboratory tests, therapies, specialists, hospital admissions, and follow-up care. Your PCP also contacts other plan providers for updates about your care and/or treatments. If you need certain types of covered services or supplies, your PCP must give approval ahead of time. This means you will need a referral to see a plan specialist. In some cases, your PCP will {also} need to get prior authorization (prior approval). Since your PCP will provide and coordinate your health care, you should have all of your past medical records sent to your new PCP's office. The law requires us to protect your privacy of your medical records and personal health information. For more information about privacy, see your Evidence of Coverage.]

How to change your PCP [FOR HMO, COST, AND PPOS THAT USE PCPS, INCLUDE THIS SECTION]

You may change your PCP for any reason, at any time. [IF APPLICABLE, YOU MAY DELETE "AT ANY TIME" AND REPLACE IT WITH TEXT THAT SPECIFIES LIMITS ON WHEN THE CHANGE MAY OCCUR, SUCH AS "AT THE END OF THE MONTH."] To change your PCP, call Member Services at [phone number], [days and hours of operation]. TTY users should call [TTY number]. [INSERT ONE OR MORE OF THE REMAINING SENTENCES, IF APPLICABLE, TO THE PLAN'S PROVIDER ARRANGEMENT, MODIFYING THE WORDING AS NEEDED FOR ACCURACY. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will {also} check that the PCP you wish to switch to is accepting new patients. Member Services {OPTIONAL: will change your membership record to show the name of your new PCP, and} will tell you when the change to your new PCP will take effect. {OPTIONAL: They will also send you a new membership card that shows the name and phone number of your new PCP.}]

What if your doctor or provider leaves [Plan Name]?

[FOR HMO, COST, AND PPOS THAT USE PCPS: Sometimes a doctor, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of {Plan Name}. If your PCP leaves {Plan Name}, we will let you know, and help you switch to another PCP so that you can continue getting covered services.]

[FOR OTHER PPOS: Sometimes a doctor, specialist, clinic, or other plan provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of {Plan Name}.]

Section 3 – Getting care from specialists

[FOR HMO, USE THIS SECTION]

[MODIFY THE DISCUSSION ABOUT REFERRALS IN THIS SECTION TO REFLECT YOUR OWN CONTRACTUAL CIRCUMSTANCES, SUCH AS OPEN ACCESS PANELS, FORMAL REFERRAL CIRCLES, OR SUB NETWORKS, ETC.]

When your PCP thinks that you need specialized treatment, he or she will give you a "referral" (approval ahead of time) to see a plan specialist. A **specialist** is a doctor who provides health care services for a specific disease or part of the body. Some examples of specialists are oncologists, who treat cancer; cardiologists, who treat heart conditions; and orthopedists, who treat certain bone, joint, or muscle conditions. For some types of referrals to plan specialists, your PCP may need to get approval ahead of time from [INSERT WHAT IS APPLICABLE: {organization name} – OR – GIVE NAME OF SPECIFIC DEPARTMENT, SUCH AS "OUR MEDICAL MANAGEMENT DEPARTMENT"] This is called "prior authorization."

It is very important to get a referral from your PCP before you see a plan specialist. However, you don't need to get a referral for certain services, see Section 4. **If you don't have a referral before you get services from a specialist, you may have to pay for these services yourself.** [MODIFY THE FOLLOWING SENTENCE AS NEEDED TO DESCRIBE THE PLAN'S PROCESS FOR REFERRALS FOR FOLLOW-UP SPECIALTY CARE: If the specialist wants you to come back for follow-up visits, be sure to check the original referral to see if these were included.]

[IF YOUR PLAN USES FORMAL REFERRAL CIRCLES WHERE EACH ENROLLEE, BY SELECTING A SPECIFIC PCP, IS ALSO SELECTING AN ENTIRE SUB-NETWORK TO WHICH HIS OR HER PCP CAN MAKE REFERRALS, INCLUDE DETAILED INFORMATION ON THE NATURE OF THE SUB-NETWORK, PROVIDER TYPES, AND REFERRAL PRACTICES AND POLICIES. IN ADDITION, REFER THE BENEFICIARY TO SECTION 2, "CHOOSING YOUR PCP," TO ENSURE THAT THEY KNOW HOW TO CHOOSE A NEW PCP IF THEY ARE UNHAPPY WITH THE REFERRAL CIRCLE USED BY THEIR CURRENT PCP. YOU MAY MODIFY THE WORDING AND/OR ORDER OF THE SENTENCES IN THE FOLLOWING PARAGRAPH AS NEEDED FOR ACCURACY IN DESCRIBING THE PLAN'S PROCESS.]

Each plan PCP has certain plan specialists they use for referrals. This means that **the** [**Plan Name**] **specialists you can use may depend on which person you chose to be your PCP.** If there are specific specialists you want to use, find out whether your PCP refers patients to these specialists. [ADD WHICHEVER PARTS OF THE REST OF THIS PARAGRAPH ARE APPLICABLE, MODIFYING THE WORDING AS NEEDED FOR ACCURACY.] You can change your PCP at any time if you want to see a plan specialist that your current PCP does not refer to. If you want to change your PCP, see Section 2. If there are specific hospitals you wish to use, find out whether [your PCP uses / the doctors you will be seeing use] these hospitals.

[FOR COST, USE THIS SECTION]

[MODIFY THE DISCUSSION ABOUT REFERRALS IN THIS SECTION TO REFLECT YOUR OWN CONTRACTUAL CIRCUMSTANCES, SUCH AS OPEN ACCESS PANELS, FORMAL REFERRAL CIRCLES, OR SUB NETWORKS, ETC.]

If your PCP thinks that you need to see a plan specialist, he or she will give you a referral (approval ahead of time). A **specialist** is a doctor who provides health care services for a specific disease or part of the body. Some examples of specialists are oncologists, who treat cancer; cardiologists, who treat heart conditions; and orthopedists, who treat certain bone, joint, or muscle conditions. For some types of referrals to plan specialists, your PCP may need to get approval ahead of time from [INSERT WHAT IS APPLICABLE: {Plan Name} – OR – GIVE NAME OF SPECIFIC DEPARTMENT, SUCH AS "OUR MEDICAL MANAGEMENT DEPARTMENT"] This is called "prior authorization."

If you don't have a referral before you get services from a specialist, you will have to pay more. You will have to pay the Original Medicare plan out-of-pocket costs (such as deductibles, copayments, and coinsurance). You won't have to pay these out-of-pocket costs if you get a referral from your PCP before you see a plan specialist. However, there are certain times when you don't need a referral (see Section 4). [MODIFY THE FOLLOWING SENTENCE AS NEEDED TO DESCRIBE THE PLAN'S PROCESS FOR REFERRALS FOR FOLLOW-UP SPECIALTY CARE: If the specialist wants you to come back for follow-up visits, be sure to check the original referral to see if these were included.]

[IF YOUR PLAN USES FORMAL REFERRAL CIRCLES WHERE EACH ENROLLEE, BY SELECTING A SPECIFIC PCP, IS ALSO SELECTING AN ENTIRE SUB-NETWORK TO WHICH HIS OR HER PCP CAN MAKE REFERRALS, INCLUDE DETAILED INFORMATION ON THE NATURE OF THE SUB-NETWORK, PROVIDER TYPES, AND REFERRAL PRACTICES AND POLICIES. IN ADDITION, REFER BENEFICIARIES TO Section 2, "CHOOSING YOUR PCP," TO ENSURE THAT HE OR SHE KNOW HOW TO CHOOSE A NEW PCP IF THEY ARE UNHAPPY WITH THE REFERRAL CIRCLE USED BY THEIR CURRENT PCP. YOU MAY MODIFY THE WORDING AND/OR ORDER OF THE SENTENCES IN THE FOLLOWING PARAGRAPH AS NEEDED FOR ACCURACY IN DESCRIBING THE PLAN'S PROCESS.]

Each plan PCP has certain plan specialists they use for referrals. This means that **the** [**Plan Name**] **specialists you can use may depend on which person you chose to be your PCP.** If there are specific specialists you want to use, find out whether your PCP sends patients to these specialists. [ADD WHICHEVER PARTS OF THE REST OF THIS PARAGRAPH ARE APPLICABLE, MODIFYING THE WORDING AS NEEDED FOR ACCURACY.] You can change your PCP at any time if you want to see a plan specialist that your current PCP does not refer to. If you want to change your PCP, see Section 2. If there are specific hospitals you want to use, find out whether [your PCP uses / the doctors you will be seeing use] these hospitals.

Remember, you can get care from non-plan providers without a referral. However, if you use non-plan providers for care that is not emergency care, including health care when you are stable (known as post-stabilization care), or urgently needed care, you will have to pay more. You will have to pay the Original Medicare Plan out-of-pocket costs (such as deductibles, copayments, and coinsurance).

[FOR PPO, USE THIS SECTION]

[PPOS THAT DO NOT REQUIRE ANY REFERRALS SHOULD START THIS SECTION WITH THE SECOND SENTENCE (DELETE FIRST SENTENCE).

[If your PCP thinks you need to see a plan specialist, he or she will give you a referral (approval ahead of time).] A **specialist** is a doctor who provides health care services for a specific disease or part of the body. Some examples of specialists are oncologists, who treat cancer; cardiologists, who treat heart conditions; and orthopedists, who treat certain bone, joint, or muscle conditions. You do not need a referral if you are going to see a non-plan specialist.

Your PCP may need to get approval ahead of time from [INSERT WHAT IS APPLICABLE: {organization name} – OR – GIVE NAME OF SPECIFIC DEPARTMENT, SUCH AS "OUR MEDICAL MANAGEMENT DEPARTMENT"]. This is called "prior authorization." [IF APPLICABLE, INSERT THE FOLLOWING SENTENCES INSTEAD OF THE PRIOR SENTENCE: Remember, you can get care from non-plan specialists without a referral or prior authorization from another doctor. However, if you use our plan specialists, your costs for covered services will be lower than if you used non-plan specialists.]

[PPOS THAT DO NOT REQUIRE ANY REFERRALS OR PRIOR AUTHORIZATION SHOULD NOT USE THE LANGUAGE IN THE REMAINDER OF THIS SECTION.]

Be sure to get a referral from your PCP before you see a plan specialist. In some cases, you don't need a referral ahead of time (see Section 4). If the specialist wants you to come back for follow-up visits, be sure to check the original referral to see if these were included.

[IF YOUR PLAN USES FORMAL REFERRAL CIRCLES WHERE EACH ENROLLEE, BY SELECTING A SPECIFIC PCP, IS ALSO SELECTING AN ENTIRE SUB-NETWORK TO WHICH HIS OR HER PCP CAN MAKE REFERRALS, INCLUDE DETAILED INFORMATION ON THE NATURE OF THE SUB-NETWORK, PROVIDER TYPES, AND REFERRAL PRACTICES AND POLICIES. IN ADDITION, REFER BENEFICIARIES TO Section 2, "CHOOSING YOUR PCP," TO ENSURE THAT THEY KNOW HOW TO CHOOSE A NEW PCP IF THEY ARE UNHAPPY WITH THE REFERRAL CIRCLE USED BY THEIR CURRENT PCP. YOU MAY MODIFY THE WORDING AND/OR ORDER OF THE SENTENCES IN THE FOLLOWING PARAGRAPH AS NEEDED FOR ACCURACY IN DESCRIBING THE PLAN'S PROCESS.]

Each plan PCP has certain plan specialists they use for referrals. This means that **the** [**Plan Name**] **specialists you can use may depend on which person you choose to be your PCP.** If there are specific plan specialists you want to use, find out whether your PCP sends patients to these specialists. [ADD WHICHEVER PARTS OF THE REST OF THIS PARAGRAPH ARE APPLICABLE, MODIFYING THE WORDING AS NEEDED FOR ACCURACY.] You can change your PCP at any time if you want to see a plan specialist that your current PCP does not refer you to. If you want to change your PCP, see Section 2. If there are specific hospitals you want to use, find out whether [your PCP uses / the doctors you will be seeing use] these hospitals.

Section 4 – Self-referrals

[FOR HMO, USE THIS SECTION]

There are certain times when you may be able to get certain services without a referral.

You will get most of your routine or basic care from your PCP. Your PCP can also coordinate your covered services. If you get services from any doctor, hospital, or other health care provider without getting a referral ahead of time from your PCP, you may have to pay for these services yourself. This also includes if you get these services from a provider in your plan.

In some cases, you can get the services listed below without a referral or approval ahead of time from your PCP. [INCLUDE THE FOLLOWING THREE SENTENCES: **"Self-referred"** means you get services on your own.

If you get self-referred services, you still have to pay a copayment. However, if you get a self-referred service from a plan provider, you will only have to pay the in-network copayment.] If you go to a non-plan provider for these services, you will have to pay more.

The following services may be self-referred:

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots [INSERT IF APPROPRIATE: and pneumonia vaccinations] (only if you get them from a plan provider).
- [INSERT ANY SERVICES FROM PLAN PROVIDERS FOR WHICH SELF-REFERRALS ARE ALLOWED.]
- Emergency services, whether you get these services from plan providers or non-plan providers, see Section 6. The emergency services including hospital care after you are stable (known as post-stabilization) are also covered.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. For more information about urgently needed care, see Section 6. For more information about the plan's service area, see Section 1.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. [YOU MAY INSERT REQUESTS HERE, E.G., IF POSSIBLE, PLEASE LET US KNOW BEFORE YOU LEAVE THE SERVICE AREA WHERE YOU ARE GOING TO BE SO WE CAN HELP ARRANGE FOR YOU TO HAVE MAINTENANCE DIALYSIS WHILE OUTSIDE THE SERVICE AREA.]

[FOR COST, USE THIS SECTION]

There are certain times when you may be able to get certain services without a referral.

You will get most of your routine or basic care from your PCP. Your PCP can also coordinate your covered services. In most situations, if you get services from any doctor, hospital, or other health care provider without getting a referral ahead of time from your PCP, you will have to pay more. You may have to pay the Original Medicare Plan out-of-pocket costs (such as deductibles, copayments, and coinsurance).

In some cases, you can get the services listed below without a referral or approval ahead of time from your PCP. [INCLUDE THE FOLLOWING THREE SENTENCES: When you obtain services on your own, we say that you have **"Self-referred."**

If you get self-referred services, you still have to pay a copayment. However, if you get a self-referred service from a plan provider, you will only have to pay the in-network copayment.] If you go to a non-plan provider for these services, you will have to pay more.

The following services may be self-referred:

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots [INSERT IF APPROPRIATE: and pneumonia vaccinations] (only if you get them from a plan provider).
- [INSERT ANY SERVICES FROM PLAN PROVIDERS FOR WHICH SELF-REFERRALS ARE ALLOWED.]
- Emergency services, whether you get these services from plan providers or non-plan providers, see Section 6. The emergency services including hospital care after you are stable (known as post-stabilization) are also covered.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. For more information about urgently needed care, see Section 6. For more information about the plan's service area, see Section 1.
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. [YOU MAY INSERT REQUESTS HERE, E.G., IF POSSIBLE, PLEASE LET US KNOW BEFORE YOU LEAVE THE SERVICE AREA WHERE YOU ARE GOING TO BE SO WE CAN HELP ARRANGE FOR YOU TO HAVE MAINTENANCE DIALYSIS WHILE OUTSIDE THE SERVICE AREA.]

[FOR PPOS, USE THIS SECTION; PPOS THAT DO NOT REQUIRE REFERRALS SHOULD NOT INCLUDE THE FOLLOWING SECTION.]

There are certain times when you may be able to get certain services without a referral.

You will get most of your routine or basic care from your PCP. Your PCP can also coordinate your covered services. If you get services from any plan doctor, hospital, or other health care provider without getting a referral ahead of time from your PCP, you may have to pay for these services yourself.

In some cases, you can get the services listed below without a referral or approval ahead of time from your PCP. [IT IS OPTIONAL TO INCLUDE THE FOLLOWING THREE SENTENCES: **"Self-referred"** means you get services on your own.

If you get self-referred services, you still have to pay a copayment. However, if you get the self-referred service from a plan provider, you will only have to pay the in-network copayment.] If you go to a non-plan provider for these services, you will have to pay more.

The following services may be self-referred:

- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), pap tests, and pelvic exams. This care is covered without a referral from your PCP *only* if you get it from a plan provider.
- Flu shots [INSERT IF APPROPRIATE: and pneumonia vaccinations] (*only* if you get them from a plan provider).
- [INSERT ANY SERVICES FROM PLAN PROVIDERS FOR WHICH SELF-REFERRALS ARE ALLOWED.]
- Emergency services, whether you get these services from plan providers or non-plan providers, see Section 6. The emergency services including hospital care after you are stable (known as post-stabilization) are also covered.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the plan's service area. For more information about urgently needed care, see Section 6. For information about the plan's service area, see Section 1.
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area. [YOU MAY INSERT REQUESTS HERE, E.G., IF POSSIBLE, PLEASE LET US KNOW BEFORE YOU LEAVE THE SERVICE AREA WHERE YOU ARE GOING TO BE SO WE CAN HELP ARRANGE FOR YOU TO HAVE MAINTENANCE DIALYSIS WHILE OUTSIDE THE SERVICE AREA.]

Section 5 – What if you need medical care when your PCP's office is closed?

[FOR HMO AND COST, USE THIS HEADING; FOR PPOS, CHANGE "PCP" TO "DOCTOR" IF APPLICABLE]

What to do if you have a medical emergency or urgent need for care and your PCP's office is closed

In an emergency, you can get care immediately. [FOR HMO AND COST: You do not have to contact your PCP or get prior authorization in an emergency.] [FOR PPO, INSERT IF APPLICABLE: You do not have to contact your PCP or get authorization in an emergency.] You can dial 911 for immediate help by phone, or go directly to the nearest emergency room, hospital, or urgent care center. For more information about emergency or urgent needed care, see Section 6.

What to do if it is <u>not</u> a medical emergency and your PCP's office is closed

If you need to talk with your [FOR HMO, COST, AND PPOS THAT USE PCP, USE: PCP; FOR OTHER PPOS, USE: doctor] or get medical care when the PCP office is closed, and it is ***not*** a medical emergency, call [INSERT THE 24-HOUR PHONE NUMBER, OR, IF THERE IS NO 24-HOUR NUMBER, GIVE DIRECTIONS FOR CALLING AFTER HOURS. ALSO, ADAPT AND EXPAND ON THE REST OF THIS PARAGRAPH, AS NEEDED, TO DESCRIBE WHAT MEMBERS SHOULD DO TO GET CARE AFTER HOURS. INCLUDE INFORMATION ABOUT PROVISIONS FOR GIVING 24-HOUR ACCESS BY PHONE TO PEOPLE WITH HEARING IMPAIRMENTS (SUCH AS A "RELAY" NUMBER THE MEMBER CAN USE TO CONTACT THEIR PCP/DOCTOR AFTER HOURS). IF THE PLAN HAS A NURSE HELPLINE, YOU SHOULD GIVE ITS NAME AND TELL MEMBERS WHEN AND HOW TO USE IT]. There is always a [doctor/plan provider/health professional] on call to help you.

For more information about what to do if you have an urgent need for care, see Section 6.

Section 6 - Getting care if you have a medical emergency or an urgent need for care

What is a medical emergency?

A situation is a "medical emergency" if **you reasonably believe that your health is in serious danger**. It means that every second counts. Some examples of "medical emergencies" are severe pain, a bad injury, a serious illness, or a medical condition that is getting worse.

What should I do if I have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go directly to the nearest emergency room. [FOR HMO, COST, AND PPOS THAT USE PCP: **In any emergency, you never need to contact any plan provider, even your own PCP, for either permission ("authorization") or referral.**]
- However, as soon as possible, you or someone else should contact [INSERT WHICHEVER ARE APPLICABLE: {name of organization}/ your PCP / your medical group] about your emergency. [INSERT INSTRUCTIONS – EITHER GIVE THE NUMBER TO CALL OR EXPLAIN WHERE TO GET THE NUMBER TO CALL (E.G., THE BACK OF THE MEMBERSHIP CARD).] Your [INSERT WHICHEVER ARE APPLICABLE: {name of organization}/ your PCP / your medical group] needs to know about your emergency because [ADAPT AS NEEDED: we / your PCP / your medical group] will provide follow-up care. [FOR HMO, COST, AND PPO DEMONSTRATIONS THAT USE PCPS: Please try to contact [INSERT WHICHEVER ARE APPLICABLE: {name of organization}/ your PCP / your medical group] about your emergency within 48 hours.

[{Plan Name} / Your PCP / Your medical group] will help manage and follow-up on your emergency care

[PPO PLANS THAT USE PCPS SHOULD INCLUDE THE REFERENCES TO PCPS IN THIS SECTION. ALL OTHER PPOS SHOULD MODIFY THIS SECTION ACCORDINGLY TO ADDRESS POST-STABILIZATION CARE.]

It is important to know that every emergency has two stages.

When the doctors, or hospital, providing emergency care consider your condition stable, the first stage of the medical emergency ends. However, even after your condition is stabilized, you are still considered in an emergency situation and {Organization name} must still pay for post-stabilization treatment provided by the hospital (whether or not this hospital is a plan provider or not). This second stage of the emergency, after your condition is stabilized is call "post-stabilization."

Generally, the hospital, or doctors, providing emergency care will try to talk to your [{Organization name} / Your PCP / Your medical group]. This helps the plan to arrange for plan providers to take over your care as soon as your condition and circumstances get better. Once your [{Organization name} / Your PCP / Your medical group] takes over your care or agree with the attending hospital on an appropriate course of action (or once you are discharged if you are fully recovered), you are no longer in an emergency or post-stabilization situation.

Although you are past the emergency and post-stabilization, you may still need follow-up care. However, your plan is responsible for your follow-up care. Your plan will only pay for follow-up care after your emergency and post-stabilization if you follow the plan rules. You will need to use plan providers to get authorization, and/or referrals.

What is covered if I have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the United States. [IF PLAN BENEFITS INCLUDE A "WORLD-WIDE" EMERGENCY BENEFIT AT NO ADDITIONAL COST, SUBSTITUTE "ANYWHERE IN THE WORLD" FOR "UNITED STATES" IN THE PRECEDING SENTENCE. IF YOUR PLAN OFFERS A SUPPLEMENTAL TRAVELER'S BENEFIT (AT ADDITIONAL COST), STATE THE AVAILABILITY OF THIS COVERAGE AND TELL MEMBERS HOW TO GET MORE INFORMATION ABOUT IT.]

- **Ambulance services** are covered in situations where other means of transportation in the United States would endanger your health. [IF PLAN BENEFITS INCLUDE A "WORLD-WIDE" EMERGENCY BENEFIT AT NO ADDITIONAL COST, SUBSTITUTE "ANYWHERE IN THE WORLD" (OR OTHER APPROPRIATE WORDING TO REFLECT THE BREADTH OF COVERAGE) FOR "UNITED STATES" IN THE PRECEDING SENTENCE.]

What if it wasn't really a medical emergency?

To have your plan pay for your emergency care, you do not have to be certain that it is an emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—but the doctor may disagree and not consider this a medical emergency. If this happens, you are still covered for the diagnostic treatment and care you received to determine what was wrong, provided that you thought your health was in serious danger, as explained in the section "What is a 'medical emergency'" above. However, please note that:

[FOR HMO:

- If you get any extra care after the doctor says it was not a medical emergency, your plan will only pay for the extra covered care **if you got this care from a plan provider**.

- If you get any extra care from a ***non-plan provider*** after the doctor says it was not a medical emergency, your plan must still pay for it as "urgently needed care" even though you got this care "outside your service area." Please read below how "urgently needed care" is defined.

- However, if you get any extra care from a non-plan provider that is not an emergency or "urgently needed care," then you must pay for this care yourself. The plan won't pay for this type of care.

FOR COST:

- If you get any extra care after the doctor says it was not a medical emergency, your plan will only pay for the extra covered care if you got this care from a plan provider.
- If you get any extra care from a ***non-plan provider*** after the doctor says it was not a medical emergency, your plan must still pay for it as "urgently needed care" even though you got this care "outside your service area." Please read below how "urgently needed care" is defined.
- However, if you get any extra care from a ***non-plan provider*** that is not emergency or "urgently needed care," then you will have to pay the Original Medicare Plan out-of-pocket costs (such as deductibles, copayments, and coinsurance).

[FOR PPOS:

- If you get any extra care after the doctor says it was not a medical emergency, the amount of the covered extra care that we pay will depend on whether you get the care from plan providers.
- If you get the care from plan providers, your costs will usually be lower than if you get the care from non-plan providers.]

What is "urgently needed care"? (This is different from a medical emergency.)

[FOR HMO: "Urgently needed care" is a non-emergency situation **when you are out of the service area and you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to wait to get medical care from plan providers. You can still get urgently needed care even if you knew about your illness or injury ahead of time, but you had an unforeseen complication.

[FOR COST: "Urgently needed care" is a non-emergency situation **when you are out of the service area and you need medical attention right away for an unforeseen illness or injury,** and it is not reasonable given the situation for you to wait to get medical care from your PCP or other plan providers. You can still get urgently needed care even if you knew about your illness or injury ahead of time, but you had an unforeseen complication.]

[FOR PPO: "Urgently needed care" is a **non-emergency situation when you need medical attention right away for an unforeseen illness or injury**, and it is not reasonable given the situation for you to wait to get medical care from {PPO PLANS THAT USE PCPS, INCLUDE: your PCP or} plan providers. You can still get urgently needed care even if you knew about your illness or injury ahead of time, but you had an unforeseen complication.

What is the difference between a "medical emergency" and "urgently needed care"?

The difference between emergency and urgently needed care is in the seriousness of the condition.

A medical emergency is when you believe your health is in serious danger, when every second counts. You may have a bad injury, sudden illness, or an illness quickly getting much worse.

Urgently needed care is care that you get for a sudden illness or injury that needs medical care right away, but is not life threatening. Your PCP generally provides urgently needed care. If you are out of your plan's service area for a short time and can't wait until you return to the service area, [Plan Name] will pay for urgently needed care.

Getting urgently needed care when you are <u>in</u> the plan's service area

[FOR HMO, USE THIS SECTION]

If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your PCP or [INSERT THE 24-HOUR PHONE NUMBER, OR, IF THERE IS NO 24-HOUR NUMBER, GIVE DIRECTIONS FOR CALLING AFTER HOURS. ALSO, ADAPT AND EXPAND ON THE REST OF THIS PARAGRAPH, AS NEEDED, TO DESCRIBE WHAT MEMBERS SHOULD DO TO GET CARE AFTER HOURS. INCLUDE INFORMATION ABOUT PROVISIONS FOR GIVING 24-HOUR ACCESS BY PHONE TO PEOPLE WITH HEARING IMPAIRMENTS (SUCH AS A "RELAY" NUMBER THE MEMBER CAN USE TO CONTACT THEIR PCP AFTER HOURS). IF THE PLAN HAS A NURSE HELPLINE, YOU SHOULD GIVE ITS NAME AND TELL MEMBERS WHEN AND HOW TO USE IT.] There will always be a [doctor / plan provider / health professional] on call to help you. [ADD THE NEXT TWO SENTENCES, ADAPTING AS NEEDED TO REFLECT YOUR PLAN'S POLICIES: Keep in mind that if you have an urgent need for care while you are in the plan's service area, you should get this care from plan providers. In most cases, we will not pay for urgently needed care that you get from a non-plan provider while you are in the plan's service area.]

Getting urgently needed care when you are <u>outside</u> the plan's service area

[FOR HMO, USE THIS SECTION]

[Plan Name] covers urgently needed care that you get from non-plan providers when you are outside the plan's service area [INSERT IF APPROPRIATE: (but still in the United States)]. If you need urgent care while you are outside the plan's service area, you should call your PCP. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the "urgently needed care" definition.

We also cover renal dialysis (kidney) services that you get when you are outside the plan's service area.

Getting urgently needed care

[FOR COST, USE THIS SECTION]

[Plan Name] covers urgently needed care that you get from non-plan providers when you are outside the plan's service area [INSERT IF APPROPRIATE: (but still in the United States)]. If you need urgent care while you are outside the plan's service area, you should call your PCP, if possible. If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the "urgently needed care" definition

We also cover renal dialysis services (kidney) that you get when you are outside the plan's service area.

Getting urgently needed care when you are in the plan's service area

[FOR PPO, USE THIS SECTION]

[PPO PLANS THAT USE PCPS - DELETE REFERENCES TO DOCTORS AND INSTEAD REFER TO PCPS] If you have a sudden illness or injury that is not a medical emergency, and you are in the plan's service area, please call your doctor or [INSERT THE 24-HOUR PHONE NUMBER, OR, IF THERE IS NO 24-HOUR NUMBER, GIVE DIRECTIONS FOR CALLING AFTER HOURS. ALSO, ADAPT AND EXPAND ON THE REST OF THIS PARAGRAPH, AS NEEDED, TO DESCRIBE WHAT MEMBERS SHOULD DO TO GET CARE AFTER HOURS. INCLUDE INFORMATION ABOUT PROVISIONS FOR GIVING 24-HOUR ACCESS BY PHONE TO PEOPLE WITH HEARING IMPAIRMENTS (SUCH AS A "RELAY" NUMBER THE MEMBER CAN USE TO CONTACT THEIR DOCTOR AFTER HOURS). IF THE PLAN HAS A NURSE HELPLINE, YOU SHOULD GIVE ITS NAME AND TELL MEMBERS WHEN AND HOW TO USE IT.] There is always a [doctor / plan provider / health professional] on call to help you. [ADD THE NEXT TWO SENTENCES, ADAPTING AS NEEDED TO REFLECT YOUR PLAN'S POLICIES: Keep in mind that if you have an urgent need for care while you are in the plan's service area, you should get this care from plan providers. You can get urgently needed care from a non-plan provider; however, your costs will be lower if you use plan providers.]

Getting urgently needed care when you are outside the plan's service area

[FOR PPO, USE THIS SECTION]

[Plan Name] covers urgently needed care that you get from non-plan providers when you are outside the plan's service area [INSERT IF APPROPRIATE: but still in the United States]. [PPO PLANS THAT USE PCPS - INCLUDE THE FOLLOWING SENTENCE: If you need urgent care while you are outside the plan's service area, you should call your PCP, if possible. PPOS THAT USE PCPS - DELETE "FROM PLAN PROVIDERS" AND INSERT "THROUGH YOUR PCP."] If you are treated for an urgent care condition while out of the service area, we prefer that you return to the service area to get follow-up care [from plan providers]. [PPOS THAT USE PCPS - INCLUDE THE FOLLOWING SENTENCE: However, we will cover follow-up care that you get from non-plan providers outside the plan's service area as long as the care you are getting still meets the "urgently needed care" definition.]

We also cover renal dialysis (kidney) services that you get when you are outside the plan's service area.

Section 7 – For more information

For more detailed information about your [Plan Name] provider coverage, please review the Evidence of Coverage.

If you have questions about [Plan Name], please call our Customer Service Department at [phone number], [days and hours of operation]. TTY users should call [TTY number]. Or, visit [Web address].

Section 8 – List of Plan Providers

[RECOMMENDED ORGANIZATION:

Type of Provider (PCP, Specialty, Skilled Nursing Facilities, Hospitals, Outpatient mental health providers, and pharmacies, where outpatient prescription drugs are offered by the Medicare Advantage plan.)

State (Include only if directory includes multiple states)

County (Listed alphabetically)

City (Listed alphabetically)

Neighborhood/Zip Code (Optional; For larger cities, providers may be further subdivided by zip code or neighborhood)

Provider (Listed alphabetically)

NOTE: PLANS MUST INDICATE HOW TYPES OF PROVIDERS CAN BE IDENTIFIED AND LOCATED RELATIVE TO ORGANIZATIONAL FORMAT.]

Primary Care Physicians

[State]

[County]

[City]

[Zip Code]

[Physician Name]

[Physician Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]

Specialists

[Specialty Type]

[State]

[County]

[City]

[Zip Code]

[Physician Name]

[Physician Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]

Hospitals

[State]

[County]

[City]

[Zip Code]

[Hospital Name]

[Hospital Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]

Skilled Nursing Facilities (SNF)

[State]

[County]

[City]

[Zip Code]

[SNF Name]

[SNF Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]

Outpatient Mental Health Providers

[State]

[County]

[City]

[Zip Code]

[Physician Name]

[Physician Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]

Pharmacies

[State]

[County]

[City]

[Zip Code]

[Pharmacy Name]

[Pharmacy Street Address, City, State, Zip Code]

[Phone number]

[WEB AND E-MAIL ADDRESSES ARE OPTIONAL]