<Plan name> *Evidence of Coverage*

* [*Plans may add a front cover to the Evidence of Coverage that contains information, such as the plan name, Evidence of Coverage title, and contact information for Member Services. Plans may add a logo and/or photographs to the front cover as long as these elements do not make it difficult for members to read other information on the cover. If plans add a front cover, it must contain the Material ID.*]
* [*Plans must use the state-specific name for Medicaid in references to “Medicaid” in any plan-customized language throughout the Evidence of Coverage*.]
* [*Plans may modify the language in the Evidence of Coverage, as applicable, to address Medicaid benefits and cost-sharing for its dual eligible population*.]
* [*Throughout the document plans should update language based on how the integrated program is described in the state as instructed by the state (i.e. one name for the plan or matching Medicare and Medicaid plans, etc.)*]
* [*Where the Evidence of Coverage uses “medical care”, “medical services”, or “health care services” to explain services provided, plans may revise and/or add references to long-term services and supports and/or home and community-based services as applicable*.]
* [*Plans may change references to terms such as “member”, “customer”, “beneficiary”, “member services”, “health risk assessment”, “care coordinator”, “primary care provider”, “prior authorization (PA)”, “prior approval”, “nursing facility”, and “urgently needed care”, etc. as instructed by the state or based on plan preference and update them consistently throughout the Evidence of Coverage*.]
* [*Where the model material instructs inclusion of a plan phone number, plans must ensure it is a toll-free number and include a toll-free TTY number and days and hours of operation*.]
* [*Throughout the Evidence of Coverage, in addition to following all Medicare and Medicaid requirements in regulation and the Medicare Communications and Marketing Guidelines, plans must follow additional applicable style rules of the state, if any*.]
* [*Plans should refer to other parts of the Evidence of Coverage using the appropriate chapter number and section as appropriate. For example, “refer to Chapter 9, Section A.” An instruction* [*insert reference, as applicable*] *appears with many cross references throughout the Evidence of Coverage. Plans may always include additional references to other sections, chapters, and/or member materials when helpful to the reader.*]
* [*Plans must include the OMB approval information in the footer of the first page of the document as noted in this model.*]
* [*Plans must include the Material ID: H number description of choice (M or C) at the bottom of the first page of the document*.]
* [*Wherever possible, plans are encouraged to adopt good formatting practices that make information easier for English-speaking and non-English-speaking enrollees to read and understand. The following are based on input from beneficiary interviews:*
* Format a section, chart, table, or block of text to fit onto a single page. In instances where plan-customized information causes an item or text to continue on the following page, enter a blank return before right aligning with clear indication that the item continues (for example, similar to the Benefits Chart in Chapter 4 of the Evidence of Coverage, insert: **This section is continued on the next page**).
* Ensure plan-customized text is in plain language and complies with reading level requirements established by the state.
* Break up large blocks of plan-customized text into short paragraphs or bulleted lists and give a couple of plan-specific examples as applicable.
* Spell out an acronym or abbreviation before its first use in a document or on a page (for example, long-term services and supports (LTSS) or low-income subsidy (LIS)). Plans may choose to spell out terms each time they are used.
* Include the meaning of any plan-specific acronym, abbreviation, or key term with its first use.
* Avoid separating a heading or subheading from the text that follows when paginating the model.
* Use universal symbols or commonly understood pictorials.
* Draft and format plan-customized text and terminology in translated models to be culturally and linguistically appropriate for non-English speakers.
* Consider using regionally appropriate terms or common dialects in translated models.
* Include instructions and navigational aids in translated models in the translated language rather than in English.]

**<start date> – <end date>**

Your Health and Drug Coverage under <plan name>

[*Plans: Revise this language to reflect that the organization is providing both Medicaid and Medicare covered benefits, when applicable*.]

[Optional: *Insert member name*.]

[Optional: *Insert member address*.]

*Evidence of Coverage* Introduction

This *Evidence of Coverage* tells you about your coverage under our plan through *<*end date*>.* It explains health care services [*plans may add references to other behavioral health (mental health and substance use disorder) services, prescription drug coverage, and long-term services and supports, as needed*]. Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Evidence of Coverage*.

**This is an important legal document. Keep it in a safe place.**

When this *Evidence of Coverage* says “we”, “us”, “our”, or “our plan”, it means <plan name>.

[*Plans that meet the 5% alternative language or Medicaid required language threshold insert:* This document is available for free in Spanish and Arabic.]

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

[*Plans also simply describe:*

* how they request a member’s preferred language other than English and/or alternate format,
* how they keep the member’s information as a standing request for future mailings and communications, so the member does not need to make a separate request each time, **and**
* how a member can change a standing request for preferred language and/or format.]

[*Plans may include either the current multi-language insert or provide a Notice of Availability. Plans that choose to use the current multi-language insert per 42 CFR §§ 422.2267(e)(31) and (e)(33) should include*: We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at <phone number>. Someone that speaks <language> can help you. This is a free service. [*This information must be included in the following languages: Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi, Japanese, and any additional languages required by the state*.]

*OR*

*Per the final rule CMS-4205-F released on April 4, 2024, §§ 422.2267(e)(31) and 423.2267(e)(33), plans may choose to provide a Notice of Availability of language assistance services and auxiliary aids and services that at a minimum states that the plan provides language assistance services and appropriate auxiliary aids and services free of charge. The plan must provide the notice in English and at least the 15 languages most commonly spoken by individuals with limited English proficiency in <State> and must provide the notice in alternate formats for individuals with disabilities who require auxiliary aids and services to ensure effective communication*.]

|  |  |
| --- | --- |
| Do you need free help with this letter?  If you speak a language other than English, help in your language is available for free. This page tells you how to get help in a language other than English. It also tells you about other help that’s available. | |
| **Spanish:Español**  ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.  Llame al 1-8----- (TRS:711). | |
| **Kurdish: کوردی**  ئاگاداری: ئەگەر بە زمانی کوردی قەسە دەکەیت، خزمەتگوزاریەکانی یارمەتی زمان، بەخۆڕایی، بۆ تۆ بەردەستە. پەیوەندی بە  1-8----- (TRS:711). بکە. | |
| **Arabic: العربية**  ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم  (رقم هاتف الصم والبكم 1-8---- (TRS:711).) | |
| **Chinese: 繁體中文**  注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-8----  (TRS:711). | |
| **Vietnamese:Tiếng Việt**  CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số  1-8----- (TRS:711). | |
| **Korean:한국어**  주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  1-8------- (TRS:711).번으로 전화해 주십시오. | |
| **French: Français**  ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-8------- (TRS:711). | |
| **Amharic: አማርኛ**  ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-8--------- (መስማት ለተሳናቸው:TRS:711 ). | |
| **Gujarati: ગુજરાતી**  **સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો**  1-8----- (TRS:711) . | |
| **Laotian: ພາສາລາວ**  ໂປດ ຊາບ: ຖ້າ ວ່າ ທ່ານ ເວົ້າ ພາ ສາ ລາວ, ການ ບໍ ລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາ ສາ, ໂດຍບໍ່ ເສັຽ ຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ ທ່ານ. ໂທ ຣ 1-8---- (TRS:711). | |
| **German: Deutsch**  ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-8----- (TRS:711). | |
| **Tagalog:Tagalog**  PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-8----- (TRS:711). |
| **Hindi:हिंदी**  ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।1-8------  (TRS:711) . पर कॉल करें। |
| **Serbo-Croatian: Srpsko-hrvatski**  OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno.  Nazovite 1-8------ (TRS- Telefon za osobe sa oštećenim govorom ili sluhom: 711 ). |
| **Russian: Русский**  ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  Звоните 1-8----- (телетайп: TRS:711 ). |
| **Nepali:नेपाली**  ध्यान दिनुहोस्: तपार्इंले नेपाली बोल्नुहुन्छ भने तपार्इंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-8------ (टिटिवाइ: TRS:711) |
| **Persian:** **فارسی**  **توجه**: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با  1-8----------- (TRS:711) تماس بگیرید. |

* Do you need help talking with us or reading what we send you?
* Do you have a disability and need help getting care or taking part in one of our programs or services?
* Or do you have more questions about your health care?

Call us for free at <DSNP Phone number>. We can connect you with the free help or service you need. (For TRS call 711.)

We obey federal and state civil rights laws. We do not treat people in a different way because of their race, color, birthplace, language, age, disability, religion, or sex. Do you think we did not help you or you were treated differently because of your race, color, birthplace, language, age, disability, religion, or sex? You can file a complaint by mail, by email, or by phone. Here are three places where you can file a complaint:

|  |
| --- |
| **TennCare Office of Civil Rights Compliance**  310 Great Circle Road, 3W, Nashville, Tennessee 37243  Email: [HCFA.Fairtreatment@tn.gov](mailto:HCFA.Fairtreatment@tn.gov) Phone: 1-855-857-1673 (TRS 711)  You can get a complaint form online at:  [www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf](https://www.tn.gov/content/dam/tn/tenncare/documents/complaintform.pdf) |
| **U.S. Department of Health & Human Services, Office for Civil Rights**  200 Independence Ave SW, Rm 509F, HHH Bldg., Washington, DC 20201  Phone: 1-800-368-1019 (TDD): 1-800-537-7697  You can file a complaint online at: [www.ocrportal.hhs.gov/ocr/portal/lobby.jsf](http://www.ocrportal.hhs.gov/ocr/portal/lobby.jsf) |

[*Plans must include an overall Table of Contents for the Evidence of Coverage after the Evidence of Coverage Introduction and before the Evidence of Coverage Disclaimers*.]

Disclaimers

* [*Plans must include all applicable disclaimers as required in federal regulations (42 CFR Part 422, Subpart V, and Part 423, Subpart V), and included in any state-specific guidance provided by <Medicaid program name>*.]
* [*Consistent with the formatting in this section, plans may insert additional bulleted disclaimers or state-required statements, including state-required disclaimer language, here*.]
* Coverage under <plan name> is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. 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 on the individual shared responsibility requirement.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about <plan name>, a health plan that coordinates all of your Medicare and TennCare services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

[*Plans must update the Table of Contents to this document to accurately reflect where the information is found on each page after plan adds plan-customized information to this template*.]

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# Welcome to our plan

[*Insert language to describe the relationship between the Medicare and Medicaid services. For example:* Our plan provides Medicare and TennCare services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators and care teams to help you manage your providers and services. They all work together to provide the care you need.]

[*Plan can include language about itself*.]

# Information about Medicare and TennCare

## B1. Medicare

Medicare is the federal health insurance program for:

* people 65 years of age or over,
* some people under age 65 with certain disabilities, **and**
* people with end-stage renal disease (kidney failure).

## B2. TennCare

TennCare is the name of Tennessee’s Medicaid program. TennCare is run by the state and is paid for by the state and the federal government. TennCare helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

* what counts as income and resources,
* who is eligible,
* what services are covered, **and**
* the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of Tennessee approved our plan. You can get Medicare and TennCare services through our plan as long as:

* we choose to offer the plan, **and**
* Medicare and the state of Tennessee allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and TennCare services is not affected.

# Advantages of our plan

[*Plans may revise this section to best reflect the coverage of the plan in the state*.] You will now get all your covered Medicare and TennCare services from our plan, including prescription drugs. **You do not pay extra to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

* You can work with us for **most** of your health care needs.
* You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
* You have access to a care coordinator. This is a person who works with you, with our plan, and with your care team to help make a care plan.
* You’re able to direct your own care with help from your care team and care coordinator.
* Your care team and care coordinator work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
* Your doctors know about all the medicines you take so they can make sure you’re taking the right medicines and can reduce any side effects that you may have from the medicines.
* Your test results are shared with all of your doctors and other providers, as appropriate.

# Our plan’s service area

[*Insert plan service area here or within an appendix. Include a map if one is available.*

*Use county name only if approved for entire county, for example: Our service area includes all counties in Tennessee.*

*For an approved partial county, use county name plus ZIP code(s) that are included, for example: Our service area includes all parts of <county> within the following ZIP code(s): <ZIP code(s)>.*

*If needed, plans may insert a table with more than one row or a short, bulleted list to describe and illustrate their service area in a way that is easy to understand*.]

Only people who live in our service area can join our plan.

**You cannot stay in our plan if you move outside of our service area**. Refer to **Chapter 8** of your Evidence of Coverage for more information about the effects of moving out of our service area.

# What makes you eligible to be a plan member

You are eligible for our plan as long as you:

* live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
* have both Medicare Part A and Medicare Part B, **and**
* are a United States citizen or are lawfully present in the United States, **and**
* are currently eligible for TennCare **and**
* Must be eligible for Long Term CareCHOICES benefits in groups 1, 2, or 3.

If you lose eligibility but can be expected to regain it within 90 days then you are still eligible for our plan.

Call Member Services for more information.

# What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs [*add additional areas covered by HRA*].

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We’ll send you more information about this HRA.

You may continue to see your previous provider or receive previous services for at least 30 days to ensure continuity of care pending the provider enrolling under the health plan or finding a new provider under the health plan to facilitate a seamless transition of those services.

# Your care team and care plan

## G1. Care team

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

A care coordinator is a person trained to help you manage the care you need. You get a care coordinator when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care coordinator and care team.

## G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and LTSS services using a person-centered approach to your needs assessment and care planning.

Your care plan includes: [*Update the description of the care plan and the process as outlined in your model of care (MOC)*].

* your health care goals, **and**
* a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

# Your monthly costs for <plan name>

[*Plans should revise this section to only include premium types that apply, delete the portions of Section H that are not applicable, and renumber any remaining portions of Section H as appropriate. If plan has no monthly premium revise section with “Our plan has no premium*”.]

Your costs may include the following:

* Plan premium (**Section H1**)
* Monthly Medicare Part B Premium (**Section H2**)
* Optional Supplemental Benefit Premium (**Section H3**)
* Medicare Prescription Payment Plan Amount (**Section H4**)

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

[*Insert as appropriate, depending on whether State Pharmaceutical Assistance Programs (SPAPs) are discussed in Chapter 2:* There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and SPAPs. OR The “Extra Help” program helps people with limited resources pay for their drugs.] **Chapter 2**, **Section H2** tells more about [*insert as applicable:* these programs *OR* this program.] If you qualify, enrolling in the program might lower your monthly plan premium.

If you *already enrolled* and are getting help from one of these programs, **the information about premiums in this *Evidence of Coverage*** [*insert as applicable***: may** *OR* **does**] **not apply to you.** [*If not applicable, omit information about the LIS Rider*.] We [*insert as appropriate*: have included *OR* sent you] a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “LIS Rider”.

## H1. Plan premium

[*If applicable, plans should revise this section to indicate that the plan premium is paid on behalf of members (e.g. by “Extra Help”, Medicaid)*.]

As a member of your plan, you pay a monthly plan premium. [*Select one of the following*: For 2025, the monthly premium for [*insert 2025 plan name*] is [*insert monthly premium amount*]]. *OR* The monthly premium amount for [*insert 2025 plan name*] is listed in [*describe attachment*.] [*Plans may insert a list or table with the state/region and monthly plan premium amount for each area included within the EOC. Plans may also include premium(s) in an attachment to the EOC*.]

[*Plans with no premium should delete this section*.]

## H2. Monthly Medicare Part B Premium

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

[*Plans that include a Medicare Part B premium reduction benefit may describe the benefit within this section*.]

[*Plans that do not have any members paying Medicare premiums or plans whose members must pay the full Medicare Part B premium should modify this section*.]

[*Plans with no monthly premium, omit: In addition to paying the monthly plan premium*,] some members are required to pay other Medicare premiums. As explained in **Section E** above, in order to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most <plan name> *members*, Medicaid pays for your Medicare Part A premium (if you don’t qualify for it automatically) and for your Medicare Part B premium.

**If Medicaid is not paying your Medicare premiums for you, you must continue to pay your Medicare premiums to remain a member of the plan.** This includes your premium for Medicare Part B. It may also include a premium for Medicare Part A which affects members who aren’t eligible for premium free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

## H3. Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called “optional supplemental benefits”, then you pay additional premium each month for these extra benefits. Refer to **Chapter 4**, **Section E** for details. [*If the plan describes optional supplemental benefits within Chapter 4, then the plan must include the premium amounts for those benefits in this section*.]

## H4. Medicare Prescription Payment Amount

If you’re participating in the Medicare Prescription Payment Plan, you’ll get a bill from your plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month’s balance, divided by the number of months left in the year.

**Chapter 2** [*insert reference, as applicable*] 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.

# Your *Evidence of Coverage*

Your *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we’ve done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website [*insert URL if different than the one in the footer or insert:* at the web address at the bottom of the page].

The contract is in effect for the months you are enrolled in our plan between <start date> and <end date>.

# Other important information you get from us

Other important information we provide to you includes your Member ID Card, [*insert if applicable:* information about how to access] a *Provider and Pharmacy Directory*, [*plans that limit DME brands and manufacturers insert*: a List of Durable Medical Equipment (DME),] and [*insert if applicable*: information about how to access] a *List of Covered Drugs,* also known as a *Formulary*.

## J1. Your Member ID Card

Under our plan, you have one card for your Medicare and TennCare services, including LTSS, certain behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:

[*Insert picture of front and back of plan ID card. Mark it as a sample card (for example, by superimposing the word “sample” on the image of the card).*]

If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your TennCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do if you get a bill from a provider.

## J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan’s network. While you’re a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at [*insert URL if different than the one in the footer or insert:* at the web address at the bottom of the page].

[*Plans must add information describing the information available in the directory*.]

When first enrolled or when there is a change to your provider, you can continue to receive your service or Medicaid for at least 30 days.

**Definition of network providers**

* Our network providers include:
* doctors, nurses, and other health care professionals that you can use as a member of our plan;
* clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
* [*Insert as applicable:* LTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.]

Network providers agree to accept payment from our plan for covered services as payment in full.

**Definition of network pharmacies**

* Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
* Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to [*insert if applicable*: help you] pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

[*Plans that limit DME brands and manufacturers insert the following section (for more information about this requirement, refer to Chapter 4 of the Medicare Managed Care Manual):*

**List of Durable Medical Equipment (DME)**

We sent you our List of DME with this *Evidence of Coverage*. This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapters 3 and 4** of your Evidence of Coverage to learn more about DME equipment.]

## J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the “*Drug List*” for short. It tells you which prescription drugs our plan covers.

The *Drug List* also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

Each year, we send you [*insert if applicable: information about how to access*] the *Drug List*, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page. [*Plans may insert information about Medicaid covered drugs*.]

## J4. The *Explanation of Benefits*

When you use your Medicare Part D prescription drug benefits, we send you a summary to help you understand and keep track of payments for your Medicare Part D prescription drugs. This summary is called the *Explanation of Benefits* (EOB).

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take [*insert, as applicable:* such as increases in price and other drugs with lower cost-sharing that may be available. You can talk to your prescriber about these lower cost options]. **Chapter 6** of your Evidence of Coverage gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

[*Plans may insert other methods for members to get their EOB*.]

# Keeping your membership record up to date

[*In the Table of Contents, section heading, and text, plans substitute the name for this file if it differs from “membership record*.”]

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get and how much they cost you**.

Tell us right away about the following:

* changes to your name, your address, or your phone number;
* changes to any other health insurance coverage, such as from your employer, your spouse’s employer, or your domestic partner’s employer, or workers’ compensation;
* any liability claims, such as claims from an automobile accident;
* admission to a nursing facility or hospital;
* care from a hospital or emergency room;
* changes in your caregiver (or anyone responsible for you); **and**
* you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

[*Plans that allow members to update this information online may describe that option here*.]

TennCare Connect is an online tool for Tennesseans to apply and manage their TennCare benefits. You can access the website: [www.tenncareconnect.tn.gov](https://tenncareconnect.tn.gov/) or call TennCare customer service at 1-855-259-0701.

## K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your Evidence of Coverage.