Marketing Guidance for Minnesota Senior Health Options (MSHO) Plans

Contract Year (CY) 2022

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Introduction

The Centers for Medicare & Medicaid Services (CMS) recently codified guidance contained in the Medicare Communications and Marketing Guidelines by integrating it with existing regulations.[1] Although the codified marketing and communications policies are not new policies, we updated this document to accurately reference the new regulations and follow the section numbers and headings used in the regulations. All Medicare Advantage-Prescription Drug (MA-PD) Plan and Special Needs Plan (SNP) sponsor requirements in 42 CFR Parts 422 and 423 apply to Minnesota Senior Health Options (MSHO) Dual Eligible SNPs (MSHO Plans) participating in the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience (Minnesota demonstration), except as clarified or modified in this document.

As defined in 42 CFR 422.2260 and 423.2260 prior to the implementation of CMS-4182-F,[2] CMS continues to consider all Contract Year (CY) 2022 MSHO Plan materials to be marketing materials, including those that promote the organization or any MSHO Plan offered by the organization; inform beneficiaries that they may enroll or remain enrolled in an MSHO Plan offered by the organization; explain the benefits of enrollment in an MSHO Plan, or rules that apply to enrollees; and/or explain how services are covered under an MSHO Plan, including conditions that apply to such coverage.

This guidance document provides information only about those sections or subsections of the regulations that are not applicable or that are different for MSHO Plans. Information in this document is applicable to all marketing done for CY 2022 benefits.

Additional Guidance for MSHO Plans

The following are additional MSHO Plan-specific modifications for CY 2022 beyond those included in the new regulations:

Non-English language requirements

We clarify that MSHO Plans must follow the instructions in the Complaint and Language Block Guidance issued by the state to meet the requirements related to non-English languages.

Formulary and formulary change notice requirements

MSHO Plans should refer to the November 1, 2018, HPMS guidance memorandum, “Part D Communication Materials,” for guidance on formulary and formulary change notice requirements. As noted in that memorandum, additional updates to reflect changes related to 42 CFR 423.120(b)(5), regarding notice of mid-year formulary changes and changes to

[1] Refer to CMS-4190-F2, Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly, which may be found in the Final Rule published on January 19, 2021 (www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicaid-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare).

[2] Refer to CMS-4182-F, Contract Year 2019 Policy and Technical Changes to the Medicare Advantage, Medicare Cost Plan, Medicare Fee-for-Service, the Medicare Prescription Drug Benefit Programs, and the PACE program, which may be found in the Final Rule published April 16, 2018 (www.federalregister.gov/documents/2018/04/16/2018-07179/medicare-program-contract-year-2019-policy-and-technical-changes-to-the-medicare-advantage-medicare, p. 16625).

the definition of an approved month's supply, will be incorporated into the Medicare Prescription Drug Benefit Manual in a future release. In addition, we note that MSHO Plans are required to adhere to all relevant new regulatory provisions and requirements.

The requirements of the November 1, 2018, HPMS guidance memorandum apply with the following modifications:

- Formulary change notices must be sent for any negative formulary change (as described in Chapter 6 of the Prescription Drug Benefit Manual), regardless of whether or not the negative formulary change applies to an item covered under Medicare or Medicaid, or as an additional drug benefit under the plan.

- Formulary change notices applicable to all formulary changes (not just Part D drug changes) must be maintained on MSHO Plan websites.

Disclosure Requirements, Provision of Specific Information, Call Centers

422.111, 422.111(h)

We clarify that hold time messages that include marketing content must be submitted in the HPMS Marketing Review Module. All other guidance in this section applies to MSHO Plans.

Definitions

422.2260, 423.2260

MSHO Plans are generally subject to marketing and beneficiary communications applicable to Medicare Advantage plans in 42 CFR Parts 422 and 423, as well as those applicable to Medicaid managed care organizations in 42 CFR Part 438. We clarify that the definition of communications and marketing as described in these sections of the regulations are not applicable to MSHO Plans. CMS continues to consider all CY 2022 MSHO Plan materials to be marketing materials as stated in the "Introduction" in this document. For any other references to communications throughout 42 CFR Parts 422 and 423, the definition of marketing materials applies, and we provide additional details about materials in Appendix A and Appendix B of this document.

Submission, Review, and Distribution of Materials

422.2261, 423.2261

CMS developed a Joint Review Process (JRP) for MSHO Plan materials under the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience that combines state and CMS review requirements and parameters. Any references herein to CMS in its role in reviewing marketing materials are also references to the state for purposes of MSHO Plan marketing material review. MSHO Plans should follow state instructions for obtaining state approval of certain materials no longer reviewed in HPMS.

CMS review of marketing materials and election forms

422.2261(b), 423.2261(b)

We clarify that, for purposes of MSHO Plan materials, there is no "deeming" of materials requiring either a dual review by CMS and the state or a one-sided state review, and

materials remain in a “pending” status until the state and CMS reviewer dispositions match. Materials that require a CMS-only review deem after the respective 10- or 45-day review period. MSHO Plans may obtain more information about the specific review parameters and timeframes for marketing materials under the Minnesota demonstration in the HPMS Marketing Review Module and Users Guide. All other guidance in these subsections of the regulations applies to MSHO Plans.

General Communications Materials and Activities Requirements

422.2262, 423.2262

We clarify that, for purposes of MSHO Plan materials, guidance related to contracts applies except for Medicaid long-term services and supports (LTSS) providers. All other guidance in this section of the regulation, except as noted below, applies to MSHO Plans.

Standardized material identification (SMID)

422.2262(d), 423.2262(d)

The provisions in these subsections of the regulations are modified as follows for MSHO Plans:

The material ID is made up of two parts: (1) MSHO Plan contract number, (i.e., H number) followed by an underscore and (2) any series of alphanumeric characters chosen at the discretion of the MSHO Plan. Use of the material ID on marketing materials must be immediately followed by the status of either approved or accepted (e.g., H1234_drugx38 Approved). **Note:** MSHO Plans should include an approved status only after the material is approved and not when submitting the material for review.

In addition, when a third party, such as a pharmacy benefit manager (PBM), creates and distributes member-specific materials on behalf of multiple organizations, it is not acceptable to use the material ID for another organization for materials the third party provides to MSHO Plan enrollees. The material must be submitted in HPMS using a separate material ID for the MSHO Plan, and that material ID must be included on the material. The remainder of this section applies to MSHO Plans, including the requirement that non-English and alternate format materials based on previously created materials may have the same material ID as the material on which they are based.

Websites

422.2265, 423.2265

General website requirements

422.2265(a), 423.2265(a)

We clarify that MSHO Plans should consult the HPMS Marketing Review Module and Users Guide for instructions about submitting websites and webpages for review.

Required Materials and Content

422.2267, 423.2267

We clarify that unless otherwise modified and/or specifically indicated in this section of the document, these sections of the regulations, and all of their subsections, apply to MSHO Plans.

Model Materials

422.2267(c), 423.2267(c)

The state uses a collaborative MSHO Plan Member Materials Workgroup for development of model materials for MSHO Plans under the demonstration. The model materials are based on the integrated model materials developed for Medicare-Medicaid Plans participating in the CMS capitated financial alignment model demonstrations. MSHO Plan-specific model materials, including an Annual Notice of Changes (ANOC), Evidence of Coverage (Member Handbook), Low Income Subsidy (LIS) Rider, and integrated enrollment forms are updated annually and made available at: www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPMarketingInformationandResources.

MSHO Plans must add required disclaimers included in Appendix B of this document, as appropriate. Adding required MSHO Plan disclaimers to Part D models does not render the documents non-model when submitted for review or accepted as File and Use materials. In addition, CMS and Minnesota have streamlined anti-discrimination language between Medicare and state Medicaid requirements for inclusion in model marketing materials. All other required Part C and Part D model materials are unchanged under the Minnesota demonstration.

Appendix A. Required Materials and Instructions for MSHO Plans

The tables on the following pages contain required materials for MSHO Plans that CMS and the state developed as part of the Minnesota Demonstration to Align Administrative Functions for Improvements in Beneficiary Experience. In addition, we provide high-level information in the tables for each material. MSHO Plans should review any noted "Guidance and Other Needed Information" as applicable. MSHO Plans should also follow state instructions for state review and approval of certain materials no longer reviewed in HPMS.

MSHO Plans may enclose additional benefit and plan operation materials with required materials, unless specifically prohibited in instructions or prohibited as noted for each material. Additional materials must be distinct from required materials and must be related to the MSHO Plan in which the beneficiary enrolled.

We clarify that the materials in the following bulleted list are also marketing materials, which are subject to review requirements and parameters in this guidance. MSHO Plans should consult the HPMS Marketing Review Module and Users Guide for instructions about uploading required materials. We also clarify that MSHO Plans should follow guidance in section 422.2267 of the regulation with respect to all other aspects of the following materials:

- Coverage/Organization Determination, Discharge, Appeals and Grievance Notices
- Enrollment and Disenrollment Notices
- Excluded Provider Letter
- Explanation of Benefits – Part D
- Low Income Premium Subsidy
- Membership ID Cards
- Mid-Year Change Notification to Enrollees
- Non-Renewal Notices
- Outbound Enrollment Verification
- Part D Transition Letter
- Prescription Transfer Letter
- Scope of Appointment
- Star Ratings Document
- Termination Notices

Annual Notice of Changes (ANOC)	
To Whom Required:	• Must be provided to current enrollees of plan, including those with October 1, November 1, and December 1 effective dates.
Timing:	• MSHO Plans must send for enrollee receipt no later than September 30 of each year. (**Note:** ANOC must be posted on MSHO Plan websites by October 15.) • Enrollees with October 1, November 1, and December 1 enrollment effective dates must receive the ANOC for the upcoming year by one (1) month after the effective date of enrollment but not later than December 15.
Method of Delivery:	Hard copy, or electronically, if enrollee has opted into receiving electronic version as permitted.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and Users Guide. • Must be submitted prior to mailing ANOCs.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• Actual Mail Dates (AMDs) and number of recipients (not the number of ANOCs mailed) must be entered into HPMS within 15 days of mailing. This includes mail dates for alternate format materials. MSHO Plans that mail in waves should enter the AMD for each wave. MSHO Plans may enter up to ten (10) waves of mailings. For instructions on meeting this requirement, refer to the *Update AMD/Beneficiary Link/Function* section of the HPMS Marketing Review Module Users Guide. **(Note:** For a single mailing to multiple recipients MSHO Plans should enter an AMD that reflects the number of recipients, not the number of ANOC/EOCs (Member Handbooks) mailed.) • MSHO Plans may include the following with the ANOC: o Summary of Benefits (SB) o Provider and Pharmacy Directory o EOC (Member Handbook) o Formulary (List of Covered Drugs) o Notification of Electronic Documents o LIS Rider o No additional plan communications unless otherwise directed
Translation Required (5% Threshold):	Yes.

ANOC and EOC (Member Handbook) Errata	
To Whom Required:	Must be provided when plan errors are found in the ANOC or EOC (Member Handbook) and sent to current enrollees.
Timing:	Must send to enrollees immediately following CMS approval.
Method of Delivery:	Hard copy or electronically if enrollee has opted into receiving electronic version as permitted.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and Users Guide. • ANOC Errata must be submitted by October 15. • EOC (Member Handbook) Errata must be submitted by November 15.
Format Specification:	Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	MSHO Plans must use an errata notice to notify enrollees of plan errors in their original documents. We clarify that errata notices should only be used to notify enrollees of plan errors in plan materials. **Note:** Any mid-year changes, including but not limited to mid-year legislative benefit additions or removals and changes in enrollment policies, should be communicated to current enrollees consistent with the "Mid-Year Change Notification" guidance in this section. The HPMS errata submission process should not be used for mid-year changes to materials that are not due to plan error. Instead plans should use the HPMS marketing module replacement function for these changes.
Translation Required (5% Threshold):	Yes.

Enrollment Form/Request	
To Whom Required:	Upon request. MSHO Plans must have available a paper enrollment form in addition to any other acceptable enrollment mechanisms.
Timing:	Not applicable.
Method of Delivery:	• Paper enrollment forms may be in hard copy or electronic format (e.g., PDF file) and must be provided via email, online portal for current members, and upon request (e.g., if beneficiary does not want to enroll telephonically or electronically). • Any enrollment mechanism outlined in enrollment guidance is acceptable for an enrollment request. • MSHO Plans are not permitted to accept enrollment requests through the Online Enrollment Center (OEC).
HPMS Timing and Submission:	• Submission required by statute. • Refer to the HPMS Marketing Review Module and Users Guide.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Eligibility, Enrollment, and Disenrollment – Medicare Managed Care Manual-Chapter 2.
Translation Required (5% Threshold):	Yes.

Evidence of Coverage (EOC) / Member Handbook	
To Whom Required:	Must be provided to all enrollees of plan.
Timing:	• Must send to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year. • New enrollees with an effective date of October 1, November 1, or December 1 should receive both an EOC (Member Handbook) for the current CY, as well as an EOC (Member Handbook) document for the upcoming CY. We clarify that, for these enrollees, the ANOC may be included in the EOC (Member Handbook) or provided separately, as well as the Formulary (List of Covered Drugs) (or a distinct and separate notice alerting enrollees how to access or receive the Formulary), and the Provider and Pharmacy Directory (or a distinct and separate notice alerting enrollees how to access or receive the directory) for the upcoming year, must be received by one (1) month after the effective date of enrollment, but not later than December 15.
Method of Delivery:	Hard copy EOC (Member Handbook) or via Electronic Notice of Documents or electronically if enrollee has opted into receiving electronic version as permitted.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and Users Guide. • Submitted prior to October 15 of each year.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	No additional information.
Translation Required (5% Threshold):	Yes.

Low Income Subsidy (LIS) Rider	
To Whom Required:	• Must be provided to all current enrollees who qualify for Extra Help. • Enrollees will get a LIS rider from the MSHO Plan telling them how much help they will receive in the benefit year toward their Part D premium, deductible, and copayments.
Timing:	• Must be provided at least once per year by September 30. • Must be sent to enrollees who qualify for Extra Help or have a change in LIS levels within 30 days of receiving notification from CMS.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and Users Guide.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	Medicare Prescription Drug Benefit Manual, Chapter 13, Section 70.2.
Translation Required (5% Threshold):	Yes.

Membership ID Cards	
To Whom Required:	Provided to all plan enrollees.
Timing:	Provided to new enrollees within 10 calendar days from receipt of CMS confirmation of enrollment or by last day of month prior to effective date, whichever is later. Must also be provided to all enrollees if information on existing card changes.
Method of Delivery:	Provided in hard copy. In addition to the hard copy, plans may also provide a digital version (e.g., app).
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and Users Guide.
Format Specification:	Model not available, must include required content. Combination health and drug cards must follow the Workgroup for Electronic Data Interchange (WEDI) standards. Standalone Part D cards must follow the National Council for Prescription Drug Program (NCPDP) standards.
Guidance and Other Needed Information:	• Cards must include Plan's website address, customer service number, and contract/PBP number. • The front of the Part D sponsor card must include the Medicare Prescription Drug Benefit Program Mark. • May not use social security number (SSN).
Translation Required (5% Threshold):	No.

Pre-Enrollment Checklist	
To Whom Required:	• Must be provided to potential enrollees with the enrollment form. • May be provided to potential enrollees with the Summary of Benefits (SB) when the SB is accompanying an enrollment form.
Timing:	Prior to enrollment.
Method of Delivery:	In the same format the enrollment form was provided.
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and Users Guide.
Format Specification:	• Model required per Appendix C. • Modifications to the disclaimer language are not permitted.
Guidance and Other Needed Information:	Refer to the model in Appendix C.
Translation Required (5% Threshold):	Yes.

The Minnesota Department of Human Services annually updates the following, based on MMCO's integrated national templates, and issues state-specific model materials to MSHO Plans.

Formulary (List of Covered Drugs)	
To Whom Required:	Must be provided to all enrollees of plan.
Timing:	Must be sent to current enrollees of plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year.
Method of Delivery:	Hard copy or via Notification of Electronic Documents or electronically, if enrollee has opted into receiving electronic version.
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and User Guide.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• MSHO Plans must make available a comprehensive integrated Formulary (List of Covered Drugs) that includes Medicare and Medicaid outpatient prescription drugs and pharmacy products provided under the plan. • Over-the-counter (OTC) items and/or supplemental benefits that are in excess of Medicaid requirements may not be included in this document. • MSHO Plans are only permitted to make available a comprehensive, not abridged, Formulary (List of Covered Drugs).
Translation Required (5% Threshold):	Yes.

Provider and Pharmacy Directory	
To Whom Required:	Must be provided to all current enrollees of the plan.
Timing:	• Must be sent to current enrollees of Plan for receipt by October 15 of each year. Must be posted on plan website by October 15 of each year. • Must update directory information any time they become aware of changes. All updates to the online provider and pharmacy directories are expected to be completed within 30 days of receiving information. Updates to hard copy provider and pharmacy directories must be completed within 30 days; however, hard copy directories that include separate updates via addenda are considered up-to-date.
Method of Delivery:	Hard copy or via Notification of Electronic Documents or electronically, if enrollee has opted into receiving electronic version.
HPMS Timing and Submission:	Refer to the HPMS Marketing Review Module and User Guide.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.

Provider and Pharmacy Directory	
Guidance and Other Needed Information:	• MSHO Plans are required to make available a single combined Provider and Pharmacy Directory. Separate pharmacy and provider directories are not permitted. MSHO Plans may print separate directories for primary care physicians (PCPs) and specialists provided both directories are made available to enrollees at the time of enrollment. • The single combined Provider and Pharmacy Directory must include all network providers and pharmacies, regardless of whether they provide Medicare or Medicaid, or additional benefits. • For MSHO Plans with multi-county service areas, the combined Provider and Pharmacy Directory may be provided for all providers by county, provided the directory includes a disclaimer that the directory only includes providers in that particular county (or counties), that a complete directory is available on the plan's website, and that the enrollee may contact the plan's customer service call center to request assistance with locating providers in other counties or to request a complete hard copy Provider and Pharmacy Directory. • MSHO Plans must submit directory updates and/or addenda pages in HPMS, and these documents are reviewed consistent with the parameters for the MSHO Plan Provider and Pharmacy Directory marketing code. • The language and guidelines issued in the August 16, 2016, HPMS memorandum, "Pharmacy Directories and Disclaimers," with the modifications as noted in the bullets above. • The Provider and Pharmacy Directory should continue to be submitted in HPMS, and we note that the material type for MSHO Plans remains configured as forced File and Use. Therefore, directories will not be prospectively reviewed by CMS or state reviewers. We also clarify that updates to the directory should not be submitted in HPMS, but rather be sent directly to the state for review.
Translation Required (5% Threshold):	Yes.

Summary of Benefits (SB)	
To Whom Required:	• Must be provided to all prospective enrollees when an enrollment form is provided. • Optional with the ANOC and as requested for other enrollees.
Timing:	Must be available by October 15 of each year, but can be released as early as October 1 of each year. Must be posted on plan website by October 15 of each year.
Method of Delivery:	Hard copy.
HPMS Timing and Submission:	• Refer to the HPMS Marketing Review Module and Users Guide. • Submitted prior to October 15 of each year.
Format Specification:	• MSHO Plan model required for current CY. • Standardized model; a non-model document is not permitted.
Guidance and Other Needed Information:	• The SB must contain a concise description of the important aspects of enrolling in the plan, as well as the benefits offered under the plan, applicable conditions and limitations, and any other conditions associated with receipt or use of benefits.
Translation Required (5% Threshold):	Yes.

Appendix B. State-specific MSHO Plan Disclaimers

We clarify that MSHO Plans include specific disclaimer language in the table below. We also clarify that, as applicable, MSHO Plans include additional disclaimers contained in subsections 422.2267(e) and 423.2267(e) of the regulations. In addition, we clarify that MSHO Plans are not required to include disclaimers on the following material types: Member ID Cards, call scripts not related to sales or enrollment, banners and banner-like ads, envelopes, outdoor advertising, text messages, and social media.

Disclaimer	Required MSHO Plan Disclaimer Language	MSHO Plan Disclaimer Instructions
Federal Contracting	<Plan's legal or marketing name> is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in <plan's legal or marketing name> depends on contract renewal.	Required on materials except those specifically excluded above.

Disclaimer	Required MSHO Plan Disclaimer Language	MSHO Plan Disclaimer Instructions
Benefits – "This is not a complete list…"	This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information call Member Services or read the Member Handbook.	Required on the SB.
Availability of Non-English Translations	ATTENTION: If you speak <language of the disclaimer>, language assistance services, free of charge, are available to you. Call <plan name> at <Member/Customer> Services <information for toll-free phone and TTY numbers, and days and hours of operation>. The call is free.	Required in applicable non-English languages in those models in Appendix A for which the last row of the table indicates, "*Translation required (5% Threshold):* Yes."
NCQA SNP Approval	<Plan name> has a Model of Care approved by the National Committee for Quality Assurance (NCQA) and Minnesota until <last contract year of NCQA and state approval of Model of Care> based on a review of <plan name>'s Model of Care.	Required on all documents that reference NCQA SNP approval. Must not include numeric SNP approval scores.

Note: For model materials, MSHO Plans must continue to include disclaimers where they currently appear in models. For non-model materials, MSHO Plans may include disclaimers as footnotes or incorporate them into the body of the material.

Appendix C. Model Pre-Enrollment Checklist for MSHO Plans

Pre-Enrollment Checklist

Before making an enrollment decision, it is important that you fully understand our benefits and rules. If you have any questions, you can call and speak to a customer service representative at [*insert customer service phone number*].

This plan is a dual eligible special needs plan (D-SNP). Your ability to enroll will be based on verification that you are entitled to both Medicare and medical assistance from a state plan under Medicaid.

Additional requirements are as follows:

- You live in our service area; and
- You have both Medicare Part A and Medicare Part B; and
- You are a United States citizen or are lawfully present in the United States; and
- You are age 65 or over.

[*D-SNPs may provide additional information if they impose restrictions to specific Medicaid eligibility category(ies).*]

Understanding the Benefits

☐ The Member Handbook (Evidence of Coverage) provides a complete list of all coverage and services. It is important to review plan coverage, costs, and benefits before you enroll. Visit [*insert MSHO Plan website*] or call [*insert MSHO Plan phone number*] to view a copy of the Member Handbook (Evidence of Coverage).

☐ Review the Provider and Pharmacy Directory (or ask your doctor) to make sure the doctors you see now are in the network. If they are not listed, it means you will likely have to select a new doctor.

☐ Review the Provider and Pharmacy Directory to make sure the pharmacy you use for any prescription medicine is in the network. If the pharmacy is not listed, you will likely have to select a new pharmacy for your prescriptions.

☐ Review the Formulary (List of Covered Drugs) to make sure your drugs are covered.

Understanding Important Rules

☐ Benefits [*insert if applicable:* and/or copays] may change on January 1, [*insert year*].

☐ Except in emergency or urgent situations, we do not cover services by out-of-network providers (doctors who are not listed in the Provider and Pharmacy Directory).