Anthem BlueCross BlueShield

Evidence of Coverage

Anthem MediBlue Access Core (PPO)
Offered by Anthem Blue Cross and Blue Shield

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2018.

1-855-690-7802, TTY **711**

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It's important we treat you fairly
That's why we follow Federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently on the basis of race, color, national origin, sex, age or disability. For people with disabilities, we offer free aids and services. For people whose primary language isn't English, we offer free language assistance services through interpreters and other written languages. Interested in these services? Call Customer Service for help (TTY: 711).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to Compliance Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040-9498. Or you can file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at 200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201 or by calling 1-800-368-1019 (TTY: 1- 800-537-7697) or online at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Get help in your language
Separate from our language assistance program, we make documents available in alternate formats. If you need a copy of this document in an alternate format, please call Customer Service.

English: You have the right to get this information and help in your language for free. Call Customer Service for help.

Spanish: Tiene el derecho de obtener esta información y ayuda en su idioma de forma gratuita. Llame al número de Servicios para Miembros para obtener ayuda.

Albanian: Keni të drejtën të merrni falas këtë informacion dhe ndihmë në gjuhën tuaj. Telefononi shërbimin për klientët nëqoftëse keni nevojë për ndihmë.

Arabic:
يحق لك الحصول على هذه المعلومات والمساعدة بلغتك مجاناً. اتصل بخدمة العملاء للمساعدة.

Burmese: သင်သည် ဤသတင်းအချက်အလက်များနှင့် ပက်သက်ပြီး သင့်ဘာသာစကားဖြင့် အခမဲ့အကူအညီ ရပိုင်ခွင့်ရှိသည်။ အကူအညီအတွက် သုံးစွဲသူ ဝန်ဆောင်မှုကို ခေါ်ဆိုပါ။

Chinese: 您有權使用您的語言免費獲得該資訊和協助。請致電客戶服務部尋求協助。

Dutch: U hebt het recht om deze informatie en hulp gratis in uw taal te krijgen. Bel de klantenservice voor hulp.

French: Vous avez le droit d'accéder gratuitement à ces informations et à une aide dans votre langue. Pour obtenir de l'aide, veuillez appeler le service client.

German: Sie haben das Recht, diese Informationen und Unterstützung kostenfrei in Ihrer eigenen Sprache zu erhalten. Bitte rufen Sie den Kundendienst an, um Hilfe anzufordern.

Hindi: आपके पास इस जानकारी और सहायता को अपनी भाषा में निःशुल्क प्राप्त करने का अधिकार है। सहायता के लिए सदस्य सेवा पर कॉल करें।

Hmong: Koj muaj cai tau txais cov ntaub ntawv no thiab tau txais kev pab txhais ua koj hom lus pub dawb rau koj. Yog xav tau kev pab hu rau Lub Chaw Muab Kev Pabcuam Rau Cov Neeg Tuaj Siv Peb Qhov Kev Pab (Customer Service).

Japanese: この情報と支援を希望する言語で無料で受けることができます。サポートが必要な場合はカスタマー サービスにお電話ください。

Korean: 귀하께는 본 정보와 도움을 비용없이 귀하의 언어로 받으실 권리가 있습니다. 도움을 받으시려면 고객 서비스부로 연락해 주십시오.

Lao:
ທ່ານມີສິດໄດ້ຮັບຂໍ້ມູນນີ້ ແລະ ຄຳແນະນຳເປັນພາສາຂອງທ່ານໂດຍບໍ່ເສຍຄ່າ. ໂທຫາຝ່າຍບໍລິການລູກຄ້າສຳລັບຄຳແນະນຳ.

Pennsylvania Dutch: Du hoscht es Recht fer des Information un koschdefrei Hilf in dei eengi Schprooch griege. Du kannscht Customer Service fer Hilf uffrufe.

Polish: Masz prawo do bezpłatnego otrzymania niniejszych informacji oraz uzyskania pomocy w swoim języku. Zadzwoń pod numer Działu Obsługi Klienta w celu uzyskania pomocy.

Punjabi: ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਇਹ ਜਾਣਕਾਰੀ ਅਤੇ ਮਦਦ ਮੁਫ਼ਤ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਦਾ ਅਧਿਕਾਰ ਹੈ। ਮਦਦ ਲਈ ਗਾਹਕ ਸੇਵਾ ਨੂੰ ਕਾਲ ਕਰੋ।

Russian: Вы имеете право получить данную информацию и помощь на вашем языке бесплатно. Для получения помощи звоните в отдел обслуживания клиентов.

Tagalog: May karapatan kang makuha ang impormasyon at tulong na ito sa sarili mong wika ng walang kabayaran. Tumawag sa Serbisyo para sa mga Kustomer para matulungan ka.

Vietnamese: Bạn có quyền được biết về thông tin này và được hỗ trợ bằng ngôn ngữ của bạn miễn phí. Hãy liên hệ với Dịch vụ khách hàng để được hỗ trợ.

Anthem BlueCross BlueShield

January 1 – December 31, 2018

Evidence of Coverage

Your Medicare health benefits and services as a member of Anthem MediBlue Access Core (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2018. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Anthem MediBlue Access Core (PPO) is offered by Anthem Blue Cross and Blue Shield. (When this *Evidence of Coverage* says "we," "us" or "our," it means Anthem Blue Cross and Blue Shield. When it says "plan" or "our plan," it means Anthem MediBlue Access Core (PPO).)

Anthem Blue Cross and Blue Shield is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal.

Please contact our Customer Service number at 1-855-690-7802 for additional information. (TTY users should call 711.) Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

This document is available to order in Braille, large print and audio tape. To request this document in an alternate format, please call Customer Service at the phone number printed on the back of this booklet.

Benefits, premium, deductible and/or copayments/coinsurance may change on January 1, 2019.

The provider network may change at any time. You will receive notice when necessary.

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2018 Evidence of Coverage
Table of contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

Chapter 1

Getting started as a member

Chapter 1. Getting started as a member

Section 1. Introduction

Section 1.1

You are enrolled in Anthem MediBlue Access Core (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Anthem MediBlue Access Core (PPO).

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

There are different types of Medicare health plans. Anthem MediBlue Access Core (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does **not** include Part D prescription drug coverage.

Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2

What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

The words "coverage" and "covered services" refers to the medical care and services available to you as a member of our plan.

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.3

Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how the plan covers your care. Other parts of this contract include your enrollment form and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for the months in which you are enrolled in the plan between January 1, 2018 and December 31, 2018.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Anthem MediBlue Access Core (PPO) after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our plan each year

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

Section 2. What makes you eligible to be a plan member?

Section 2.1

Your eligibility requirements

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

- You have both Medicare Part A and Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- *-- and --* you live in our geographic service area (Section 2.3 below describes our service area). If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999.
- *-- and --* you are a United States citizen or are lawfully present in the United States
- *-- and --* you do *not* have end-stage renal disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated.

Section 2.2

What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities or home health agencies).
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3

Here is the plan service area for Anthem MediBlue Access Core (PPO)

Although Medicare is a Federal program, our plan is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in WI: Brown, Calumet, Dodge, Fond du Lac, Green Lake, Jefferson, Kenosha, Kewaunee, Langlade, Lincoln, Manitowoc, Marathon, Marinette, Milwaukee, Oconto, Outagamie, Ozaukee, Portage, Rock, Shawano, Sheboygan, Taylor, Walworth, Washington, Waukesha, Waupaca, Waushara, Winnebago

We offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of state and into a state that is still within our service area, you must call Customer Service in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Customer Service to find out if we have a plan in your new state.

If you plan to move out of the service area, please contact Customer Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

Section 2.4

U.S. Citizen or Lawful Presence

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

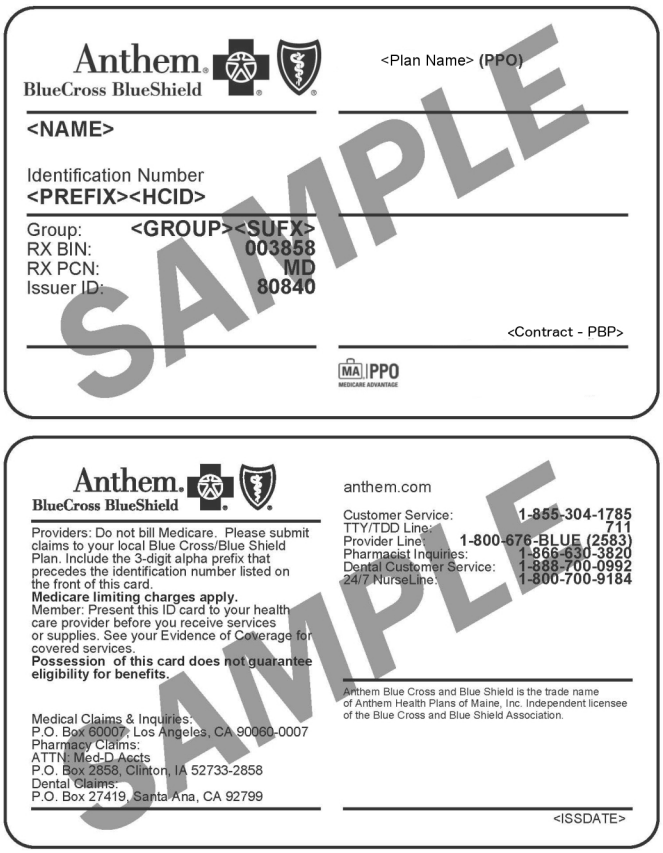
Section 3. What other materials will you get from us?

Section 3.1

Your plan membership card – use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan. You should also show the provider your Medicaid card, if applicable.

Here's a sample membership card to show you what yours will look like:



As long as you are a member of our plan, **you must *not* use your red, white and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white and blue Medicare card instead of using your Anthem MediBlue Access Core (PPO) membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost or stolen, call Customer Service right away, and we will send you a new card. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 3.2

The *Provider Directory:* your guide to all providers in the plan's network

The *Provider Directory* lists our network providers.

What are "network providers"?

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

Why do you need to know which providers are part of our network?

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 *(Using the plan's coverage for your medical services)* for more specific information.

If you don't have your copy of the *Provider Directory,* you can request a copy from Customer Service (phone numbers are printed on the back cover of this booklet). You may ask Customer Service for more information about our network providers, including their qualifications.

You can also see the *Provider Directory* at https://shop.anthem.com/medicare, or download it from this website. Both Customer Service and the website can give you the most up-to-date information about changes in our network providers.

Section 4. Your monthly premium for Anthem MediBlue Access Core (PPO)

Section 4.1

How much is your plan premium?

You do not pay a separate monthly plan premium for our plan. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits

The monthly premium for the Preventive Dental Package is $21.00. The monthly premium for the Dental and Vision Package is $30.00. The monthly premium for the Enhanced Dental and Vision Package is $42.00. If you have any questions about your plan premiums, please call Customer Services (phone numbers are printed on the back cover of this booklet).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Your copy of *Medicare & You 2018* gives information about these premiums in the section called "2018

Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes.

Everyone with Medicare receives a copy of *Medicare & You* each year, in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (https://www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2

Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September, and the change will take effect on January 1.

Section 5. Please keep your plan membership record up to date

Section 5.1

How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage, including your primary care provider/ medical group/IPA.

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

Let us know about these changes

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

If any of this information changes, please let us know by calling Customer Service (phone numbers are printed on the back cover of this booklet).

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

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or, if you have other coverage that is not listed, please call

Customer Service (phone numbers are printed on the back cover of this booklet).

Section 6. We protect the privacy of your personal health information

Section 6.1

We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.4 of this booklet.

Section 7. How other insurance works with our plan

Section 7.1

Which plan pays first when you have other insurance?

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Customer Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

Section 1. Anthem MediBlue Access Core (PPO) contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to our plan's Customer Service. We will be happy to help you.

Customer Service – contact information

Call:	1-855-690-7802. Calls to this number are free. From October 1 through February 14, Customer Service representatives will be available to answer your call directly from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. Beginning February 15, Customer Service representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. Our automated system is available any time for self-service options. You can also leave a message after hours and on weekends and holidays. Please leave your phone number and the other information requested by our automated system. A representative will return your call by the end of the next business day. Customer Service also has free language interpreter services available for non-English speakers.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-877-664-1504
Write:	Anthem Blue Cross and Blue Shield Customer Service P.O. Box 105187 Atlanta, GA 30348-5187
Website:	https://shop.anthem.com/medicare

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

You may call us if you have questions about our coverage decision process.

Coverage decisions for medical care – contact information

Call:	1-855-690-7802. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-877-664-1504
Write:	Anthem Blue Cross and Blue Shield Coverage Determinations P.O. Box 105187 Atlanta, GA 30348-5187
Website:	https://shop.anthem.com/medicare

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Appeals for medical care — contact information

Call:	1-855-690-7802. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-888-458-1406
Write:	Anthem Blue Cross and Blue Shield - Medicare Advantage Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Website:	https://shop.anthem.com/medicare

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Complaints about medical care — contact information

Call:	1-855-690-7802. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-888-458-1406
Write:	Anthem Blue Cross and Blue Shield - Medicare Advantage Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare Website:	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services).*

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment requests — contact information

Call:	1-855-690-7802. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Calls to this number are free.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Calls to this number are free.
Write:	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187
Website:	www.anthem.com

Section 2. Medicare (how to get help and information directly from the Federal Medicare program)

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including us.

Medicare – contact information

Call: 1-800-MEDICARE, or 1-800-633-4227. Calls to this number are free, 24 hours a day, 7 days a week.

TTY: 1-877-486-2048

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Website: https://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan:

- **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/Home.aspx. Medicare

takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. The SHIP for your state is listed below.

SHIPs are independent (not connected with any insurance company or health plan). They are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare.

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

In Wisconsin:
Wisconsin SHIP (SHIP) – contact information

Call: 1-800-242-1060

TTY: 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: Wisconsin SHIP (SHIP)
One West Wilson St.
Madison, WI 53703

Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Section 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. The Quality Improvement Organization for your state is listed below.

The Quality Improvement Organization has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. The Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization for your state in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

In Wisconsin:
KEPRO - Area 4 – contact information

Call: 1-855-408-8557 Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time) Weekends and Holidays: 11:00 a.m. - 3:00 p.m. (Local Time)

TTY: 1-855-843-4776

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: KEPRO - Area 4
5201 W. Kennedy Blvd
Suite 900
Tampa, FL 33609

Website: www.keproqio.com/default.aspx

Section 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or ESRD and meet certain conditions, are eligible for Medicare.

If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare.

To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

Social Security – contact information

Call: 1-800-772-1213

Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY: 1-800-325-0778

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.

Website: https://www.ssa.gov

Section 6. Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums and other cost sharing (like deductibles, coinsurance and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency in your state (listed below).

In Wisconsin:

Wisconsin Medicaid – contact information

Call: 1-800-362-3002 8:00 a.m. - 6:00 p.m. Monday through Friday

TTY: 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: Wisconsin Medicaid
1 West Wilson Street
Madison, WI 53703

Website: https://www.dhs.wisconsin.gov/

Section 7. How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Railroad Retirement Board – contact information

Call: 1-877-772-5772

Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY: 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

Website: https://secure.rrb.gov

Section 8. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions.

You can ask about your (or your spouse's) employer or retiree health benefits, premiums or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227); TTY: 1-877-486-2048, with questions related to your Medicare coverage under this plan.

Chapter 3

Using the plan's coverage for your medical services

Chapter 3. Using the plan's coverage for your medical services

Section 1. Things to know about getting your medical care covered as a member of our plan

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 *(Medical Benefits Chart, what is covered and what you pay).*

Section 1.1

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

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **"Covered services"** include all the medical care, health care services, supplies and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

Section 1.2

Basic rules for getting your medical care covered by the plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Our plan will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services or supplies, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this Chapter).
  - The providers in our network are listed in the *Provider Directory*.
  - If you use an out-of-network provider, your share of the costs for your covered services may be higher.
  - **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving

services to confirm that they are eligible to participate in Medicare.

Section 2. Using network and out-of-network providers to get your medical care

Section 2.1

You may choose a primary care provider (PCP) to provide and oversee your medical care

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

When you become a member of our plan, you may choose a plan provider to be your Primary Care Provider (PCP). Your PCP is a physician who meets state requirements and is trained to give you basic medical care. PCPs are licensed and credentialed. Your PCP will provide most of your care and will help you arrange or coordinate most other care you need.

Providers who practice in any of the following medical fields are considered PCPs:

- General practice
- Family Medicine
- Internal Medicine
- Pediatrics

You will usually see your PCP first for most of your routine health care needs. Your PCP will arrange for most other services, including X-rays, laboratory tests and hospital care.

In certain situations, your PCP may need to give you approval in advance before you can use providers in the plan's network. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.

Referrals from your PCP are not required for emergency care or urgently needed services. There are also some other kinds of care you can get without having approval in advance from your PCP. For more information about this, see Section 2.2 of this chapter.

How do you choose your PCP?

You may have selected a PCP when you completed your enrollment form.

If you need help finding a network provider, please call Customer Service at the number listed on your membership card, or visit our website to access our online, searchable directory. If you would like a *Provider Directory* mailed to you, you may call Customer Service, or request one at our website. To help you make your selection, our online provider search allows you to choose providers near you and gives information about the doctor's gender, language, hospital affiliations and board certifications.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers, and you would have to find a new PCP in our plan, or you will pay more for covered services. If your request to change your PCP is made on days 1-14 of the month, the effective date of your PCP change will default to the first of the current month in which you have requested your PCP change. If your request to change your PCP is made on days 15-31 of the month, the effective date of your PCP change will default to the first of the following month.

To change your PCP, call Customer Service. When you call, be sure to tell Customer Service if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Customer Service can assist with transition of care if you are currently getting treatment from a specialist.

The Customer Service representative will also check to be sure the new PCP you selected is accepting new patients. Then, Customer Service will change your membership record to show the name of your new PCP and tell you when the change will be effective. Customer Service will also send you a new

membership card that shows the name of your new PCP.

Section 2.2

What kinds of medical care can you get without getting approval in advance from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests and pelvic exams.
- Flu shots, Hepatitis B vaccinations and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.
- Abdominal aortic aneurysm screening
- Annual routine physical
- Bone mass measurement
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease).
- Cardiovascular disease testing
- Colorectal cancer screening
- Depression screening
- Diabetes screening, diabetes self-management training, diabetes services and supplies.
- Health and wellness education programs.
- HIV screening
- Medical nutrition therapy
- Obesity screening and therapy to promote sustained weight loss.
- Prostate cancer screening
- Screening and counseling to reduce alcohol misuse.
- Screening for Hepatitis C.
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs.
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use).
- Welcome to Medicare preventive visit and annual wellness visit.

Section 2.3

How to get care from specialists and other network providers

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

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

If you need help finding a network specialist, please call Customer Service at the number listed on your membership card, or visit our website to access our online, searchable directory. If you would like a *Provider Directory* mailed to you, you may call Customer Service, or request one at our website.

You are encouraged to get a referral (approval in advance) from your network PCP before you see a network contracted specialist or receive specialty services with the exception of those services listed above under Section 2.2. Please refer to Chapter 4, Section 2.1 for information about which services require referrals and/or prior authorizations. If you use an out-of-network provider, you pay the out-of-network cost sharing even if you receive a referral for the services, or if you request a pre-visit coverage decision from the plan. In the event that a contracted provider is not available, you can ask to

access care at an in-network cost sharing from an out-of-network provider.

For certain services, your provider of care will need to get prior approval from us. This is called getting "prior authorization." For services that require prior authorization, see the Medical Benefits Chart in Chapter 4, Section 2.

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but, if your doctor or specialist does leave your plan, you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider, or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider and managing your care.

For assistance, please call Customer Service at the phone numbers printed on the back cover of this booklet.

Section 2.4

How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. **However, if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider, before receiving services, to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, you may want to ask for a previsit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a previsit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage, and you will be responsible for the

entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or, if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services)* for information about what to do if you receive a bill, or, if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1

Getting care if you have a medical emergency

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

A **"medical emergency"** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help, or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the number on the back of your plan membership card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

This plan provides limited coverage for emergency care outside of the United States. Prescriptions purchased outside of the country are not covered even for emergency care.

When you receive emergency/urgent care outside the country, you will need to pay the bill and ask for an itemized bill for your services. When you return to the United States, send the itemized bill and proof of payment to us along with a note describing your emergency/urgent care you received. If you did not pay your bill in U.S. dollars, the plan will reimburse you in U.S. dollars at the current exchange rate. See Chapter 5, Section 2 for more information on how to submit a bill for reimbursement, and the Medical Benefits Chart in Chapter 4 for additional information.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who

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

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

If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost sharing.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

Section 3.2

Getting care when you have an urgent need for services

What are "urgently needed services"?

"Urgently needed services" are nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, and you use an out-of-network provider, you will pay a higher share of the costs for your care.

If you need help finding a network provider, please call Customer Service at the number listed on your membership card, or visit our website to access our online, searchable directory. If you would like a *Provider Directory* mailed to you, you may call Customer Service, or request one at our website.

What if you are *outside* the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the lower, in-network cost-sharing amount.

Our plan offers limited supplemental urgently needed medical care coverage for occasions when you are outside of the United States. Please refer to the Medical Benefits Chart in Chapter 4 for more details.

Section 3.3

Getting care during a disaster

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

Please visit the following website: https://shop.anthem.com/medicare for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain

care from out-of-network providers at in-network cost sharing.

Section 4. What if you are billed directly for the full cost of your covered services?

Section 4.1

You can ask us to pay our share of the cost of your covered services

If you have paid more than your share for covered services, or, if you have received a bill for the full cost of covered medical services, go to Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services)* for information about what to do.

Section 4.2

If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan-covered services, or plan rules were not followed.

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

Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. When the benefit limit has been reached, the costs you pay will not count toward your out-of-pocket maximum. You can call Customer Service when you want to know how much of your benefit limit you have already used.

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

Section 5.1

What is a "clinical research study"?

A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works, and, if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the

covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.**

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2

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

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (https://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 6. Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1

What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility.

If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution.

You may choose to pursue medical care at any time, for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2

What care from a religious non-medical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *nonreligious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - *– and –* you must get approval in advance from our plan, before you are admitted to the facility, or your stay will not be covered.

The Medicare inpatient hospital coverage limits apply to care received in a religious non-medical health care institution. For more information, see the Medical Benefits Chart in Chapter 4.

Section 7. Rules for ownership of durable medical equipment

Section 7.1

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

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, you will acquire ownership of the DME items following a rental period not to exceed 13 months from an in-network provider or a 13 month rental period from a non-network provider. Your copayment will end when you obtain ownership of the item. Oxygen related equipment rental is 36 months before ownership transfers to the member.

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

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

If you made fewer than 13 payments for the DME item under Original Medicare before you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

Chapter 4

Medical Benefits Chart (what is covered and what you pay)

Chapter 4. Medical Benefits Chart (what is covered and what you pay)

Section 1. Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1

Types of out-of-pocket costs you may pay for your covered services

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

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2, tells you more about your plan deductible.)
- A "**copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Customer Services.

Section 1.2

What is your plan deductible?

Your deductible is $500.00. This is the amount you have to pay out of pocket before we will pay our share for your covered medical services.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services that are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services, and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- All in-network covered services
- All in-network and out-of-network emergency and urgently needed services
- The below in-network and out-of-network benefits not covered under Original Medicare (described in the benefits chart within Section 2).
  - Routine dental services
  - Routine vision services
  - Routine hearing services

Section 1.3

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

Under our plan, there are two different limits on what you have to pay out of pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $5,900. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $5,900 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $10,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $10,000 for covered Part A and Part B services, you will have 100% coverage, and will not have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4

Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles, you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute, and we don't pay certain provider charges.

Here is how this protection works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the

Medicare payment rate for non-participating providers.

- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2. Use the *Medical Benefits Chart* to find out what is covered for you and how much you will pay

Section 2.1

Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services the plan covers and what you pay out of pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services, *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from our plan.
  - Covered services that need approval in advance to be covered as in-network services are marked by a note in the Medical Benefits Chart.
  - You never need approval in advance for out-of-network services from out-of-network providers.
  - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018* Handbook. View it online at https://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Services That Are Covered for You	What You Must Pay When You Get These Services
 **Abdominal aortic aneurysm screening** A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for this preventive screening if you are eligible. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Ambulance services ▪ Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. ▪ Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**In- and Out-of-Network:** **$295** copay for each covered, one-way ambulance trip by ground or water. **20%** as your portion of covered charges for each air ambulance trip. **In-Network:** Your provider must get an approval from the plan before you get ground, air or water transportation that's not an emergency. This is called getting prior authorization. **Out-of-Network:** You or your provider are encouraged to get prior approval from the plan before you get ground, air or water transportation that's not an emergency. Claims

Services That Are Covered for You	What You Must Pay When You Get These Services
	received without approval are subject to review and may include a medical necessity evaluation.
Annual routine physical exam In addition to the "Welcome to Medicare" exam or the annual wellness visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases. Please note: Additional cost share may apply for additional services or testing performed during your visit as described for each service in this medical chart.	**In-Network:** **$0** copay for one routine physical exam each calendar year. **Out-of-Network:** **$60** copay for one routine physical exam each calendar year.
 **Annual wellness visit** If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. ***Note:*** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for the annual wellness visit. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
 **Bone mass measurement** For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each bone mass measurement.

Services That Are Covered for You	What You Must Pay When You Get These Services
bone quality, including a physician's interpretation of the results.	**In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Breast cancer screening (mammograms) Covered services include: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Clinical breast exams once every 24 months	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each screening mammogram. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-Network:** **$35** copay for each covered therapy visit to treat you if you've had a heart condition. You may need an approval from the plan before the care. This is called getting a prior authorization. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each therapy visit to treat you if you've had a heart condition. You or your provider are encouraged to get prior approval from the plan for this service. Claims

Services That Are Covered for You	What You Must Pay When You Get These Services
	received without approval are subject to review and may include a medical necessity evaluation.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each visit to lower your risk for heart disease. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for cardiovascular disease testing that is covered once every five years. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Cervical and vaginal cancer screening Covered services include: ▪ For all women: Pap tests and pelvic exams are covered once every 24 months ▪ If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each Pap and pelvic exams. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Chiropractic services Covered services include: ▪ We cover only manual manipulation of the spine to correct subluxation	**In-Network:** **$20** copay for each covered visit to see a chiropractor. Visits that are covered are to adjust alignment problems with the spine. This is called manual manipulation of the spine to fix subluxation. You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Provider (PCP). **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **$60** copay for each covered visit to see a chiropractor. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
Colorectal cancer screening For people 50 and older, the following are covered: ▪ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: ▪ Guaiac-based fecal occult blood test (gFOBT) ▪ Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years. For people at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy (or screening barium enema as an alternative) every 24 months Includes the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam For people not at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **$0** copay for a biopsy or removal of tissue during a screening exam of the colon. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for a covered screening to be sure you don't have a colon condition. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Dental services - Medicare-covered In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare.	**In-Network:** For Medicare-covered dental benefits, you must use a provider that is part of the Anthem MediBlue Access Core (PPO) specialty medical network. These providers can be located in the specialty section of the provider directory. For more information on benefits and providers, call Customer Service at the phone number printed on the back cover of this booklet. **$0** copay for Medicare-covered dental services. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **$0** copay for Medicare-covered dental services.

Services That Are Covered for You	What You Must Pay When You Get These Services
Dental services - Supplemental This plan covers additional dental coverage not covered by Original Medicare. We cover: ▪ Routine dental exam(s) ▪ Routine cleaning(s)	Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 for more options. We cover more dental care than what Medicare covers but you must use a dentist in the Liberty Dental (Guardian) network. You can find these dentists in the Liberty Dental Providers section of the Provider Directory. To learn more, call Liberty Dental at 1-888-700-0992 or visit https://client.libertydentalplan.com/anthem/FindADentist. To be covered in-network, you need to use a provider that is contracted with our dental vendor to provide supplemental dental services. Any costs you pay for supplemental dental care will not count toward your maximum out-of-pocket amount. This plan covers the following preventive dental services designed to help prevent disease: ▪ 1 oral exam(s) every year ▪ 1 cleaning(s) every year **In-Network:** **$0** copay for covered preventive dental services designed to help prevent disease. **Out-of-Network:** Care rendered by a Provider that is not part of our supplemental dental network is covered as out-of-network. **20%** as your portion of the covered charges for dental services designed to help prevent disease.
 **Depression screening** We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for annual depression screening.

Services That Are Covered for You	What You Must Pay When You Get These Services
	In- and Out-of-Network: If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each diabetes screening. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: ▪ Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors ▪ For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two	**In- and Out-of-Network:** This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. Lancets may be purchased at either a pharmacy or Durable Medical Equipment provider. However lancets are limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug

Services That Are Covered for You	What You Must Pay When You Get These Services
additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. ▪ Diabetes self-management training is covered under certain conditions	Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. If you are using a brand of diabetic test strips, lancets or meters that is not covered by our plan, we will continue to cover it for up to two fills during the first 90 days after joining our company. This 90 day transitional coverage is limited to once per lifetime. During this time, talk with your doctor to decide what brand is medically best for you. This plan covers one blood glucose monitor every six months. We cover up to 100 test strips per month. We cover up to 100 lancets per month. Your provider must get an approval from the plan before we'll pay for test strips or lancets greater than the amount listed above or are not from the approved manufacturers. **In-Network:** **$0** copay for: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Blood glucose monitors **$0** copay for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider. **$0** copay for covered charges for training to help you learn how to monitor your diabetes. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for: ▪ Blood glucose test strips ▪ Lancet devices and lancets ▪ Blood glucose monitors

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider. Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for training to help you learn how to monitor your diabetes.
Durable medical equipment (DME) and related supplies (For a definition of "Durable Medical Equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.anthem.com/medicare.	**In-Network:** **20%** as your portion of the covered charges for durable medical equipment. Your provider must get our approval for items such as powered vehicles, powered wheelchairs and related items, and wheelchairs and beds that are not standard. Your provider must also get approval for therapeutic continuous glucose monitors covered by Medicare. You must get durable medical equipment through our participating plan suppliers. You cannot purchase these items from a pharmacy. If you receive a durable medical equipment item during an inpatient stay in a hospital or skilled nursing facility, the cost will be included in your inpatient claim. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for durable medical equipment. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Emergency care Emergency care refers to services that are:	**In- and Out-of-Network:** **$80** copay for each covered emergency room visit.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Furnished by a provider qualified to furnish emergency services, and ▪ Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Emergency care coverage is worldwide.	If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital. When you are outside the United States or its territories, this plan provides coverage for emergency/urgent services only. This is a supplemental benefit and not a benefit covered under the Federal Medicare program. This benefit applies if you are traveling outside the United States for less than six months. This benefit is limited to **$25,000** per year for covered emergency/urgent services related to stabilize your condition. You are responsible for all costs that exceed **$25,000,** as well as all costs to return to your service area. You may have the option of purchasing additional travel insurance through an authorized agency. If you need emergency care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 800-810-BLUE or collect at 804-673-1177. Our representatives can help you 24 hours a day, 7 days a week, 365 days a year. **$80** copay for each covered urgent care visit, emergency ground transportation, or emergency room visit worldwide.
Health and wellness education programs These programs are designed to enrich the health and lifestyles of members. ▪ Nurse HelpLine: As a member, you have access to a 24-hour Nurse HelpLine, 7 days a week, 365 days a year. - see Nurse HelpLine for more details ▪ SilverSneakers® Fitness Program - see SilverSneakers® for more details	Any costs you pay for health and wellness programs will not count toward your maximum out-of-pocket amount. **$0** copay for health and wellness programs covered by this plan.

Services That Are Covered for You	What You Must Pay When You Get These Services
Hearing services - Medicare-covered Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	**In-Network:** For Medicare-covered hearing benefits, you must use a provider that is part of the Anthem MediBlue Access Core (PPO) specialty medical network. These providers can be located in the specialty section of the provider directory. For more information on benefits and providers, call Customer Service at the phone number printed on the back cover of this booklet. **$40** copay for each Medicare-covered hearing exam to determine if you need medical treatment for a hearing condition. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each Medicare-covered hearing exam to determine if you need medical treatment for a hearing condition.
Hearing services - Supplemental This plan covers additional hearing coverage not covered by Original Medicare. We cover: ▪ Routine hearing exam ▪ Routine hearing exam and fitting/evaluation ▪ Hearing aids	Any cost you pay for routine hearing services will not count toward your maximum out-of-pocket amount. **In-Network:** We cover more hearing care than what Medicare covers but you must use a doctor in the Hearing Care Solutions network. You can find these doctors at www.hearingcaresolutions.com/Locations. To learn more, call Hearing Care Solutions at 1-855-312-2545 or visit http://hearingcaresolutions.com/anthem-members. **$0** copay for one routine hearing exam every year and one hearing aid fitting/evaluation every year. This plan covers up to **$3,000** combined In-and Out-of-Network for hearing aids and supplies every year. After plan paid benefits, you are responsible for the remaining cost. You must select a device from the Hearing Care Solutions covered list.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Covered devices are: Beltone Legend 6, Oticon Nera 2 Pro, Oticon Opn 3, Oticon Dynamo 6, Rexton Emerald 40, Siemens Primax 3, Ace, Carat, Insio One Mic, Insio Twin Mic, Motion P, Motion Sa, Motion Sx, Pure, Silk 12, Starkey Halo i70, Starkey Muse, i1600, Widex Beyond 220 Widex Unique 330 You get a one-year supply of batteries. You get a three-year warranty. It covers loss and damage. **Out-of-Network:** **40%** as your portion of the covered charges for one routine hearing exam and one fitting/evaluation every year. This plan covers up to **$59** for hearing exams and hearing aid fittings/evaluations every year. After plan paid benefits, you are responsible for the remaining cost. This plan allows up to **$3,000** combined In-and Out-of-Network for hearing aids and supplies each year. Out-of-Network, you are responsible for **50%** of the allowed amount. After plan paid benefits, you are responsible for the remaining cost. Hearing aids must be purchased through Hearing Care Solutions and must be selected from the covered device list. Covered devices are: Beltone Legend 6, Oticon Nera 2 Pro, Oticon Opn 3, Oticon Dynamo 6, Rexton Emerald 40, Siemens Primax 3, Ace, Carat, Insio One Mic, Insio Twin Mic, Motion P, Motion Sa, Motion Sx, Pure, Silk 12, Starkey Halo i70, Starkey Muse, i1600, Widex Beyond 220 Widex Unique 330 Benefits received out of network are subject to in-network benefit maximums, limitations and/or exclusions. The total in-network and out of network allowance combined cannot exceed the benefit maximum.

Services That Are Covered for You	What You Must Pay When You Get These Services
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: ▪ One screening exam every 12 months For women who are pregnant, we cover: ▪ Up to three screening exams during a pregnancy	**In-Network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each preventive HIV screening. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: ▪ Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies	**In-Network:** **$0** copay for each covered visit from a home health agency. All services must be coordinated by your Primary Care Provider (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each covered visit from a home health agency. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: ▪ Drugs for symptom control and pain relief ▪ Short-term respite care ▪ Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: ▪ If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services ▪ If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by our plan but are not covered by Medicare Part A or B : the plan will continue to cover plan-covered services that are not	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. **In-Network:** **$10** copay if you get a hospice consultation by a Primary Care Provider (PCP) before you elect hospice. **$40** copay if you get a hospice consultation by a specialist before you elect hospice. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay a **$40** copay if you get a hospice consultation by a Primary Care Provider (PCP) before you elect hospice. Once you meet the **$500** yearly deductible, you pay a **$60** copay if you get a hospice consultation by a specialist before you elect hospice.

Services That Are Covered for You	What You Must Pay When You Get These Services
covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. ***Note:*** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: ▪ Pneumonia vaccine ▪ A different, second pneumonia vaccine if received one year (or later) after the first vaccine is given. Talk with your doctor or other health care provider to see if you need one or both of the pneumococcal shots. ▪ Flu shots, once a year in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules	**In-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. The shingles shot is only covered under the Part D Prescription Drug benefit. This plan does not cover Part D prescription drugs. Please go to your prescription drug carrier for coverage. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each pneumonia, influenza, and Hepatitis B vaccine. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a	**In-Network:** For covered hospital stays: Days 1 - 6: **$295** copay per day, for each admission. Days 7 - 90: **$0** copay per day, for each admission.

Services That Are Covered for You	What You Must Pay When You Get These Services
doctor's order. The day before you are discharged is your last inpatient day. This plan covers unlimited inpatient days. Covered services include but are not limited to: ▪ Semi-private room (or a private room if medically necessary) ▪ Meals including special diets ▪ Regular nursing services ▪ Costs of special care units (such as intensive care or coronary care units) ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Necessary surgical and medical supplies ▪ Use of appliances, such as wheelchairs ▪ Operating and recovery room costs ▪ Physical, occupational, and speech language therapy ▪ Inpatient substance abuse services ▪ Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and one	This plan covers an unlimited number of additional inpatient hospital days. You pay no copay for additional inpatient hospital days. The hospital should tell the plan within one business day of any emergency admission. Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation, substance abuse, or transplant that you and your doctor planned ahead. This is called getting prior authorization. If you get inpatient care at an out-of-network hospital after your emergency condition is stable, your cost is the cost share you would pay at a network hospital. **Out-of-Network:** For covered hospital stays: Once you meet the **$500** yearly deductible, you pay **30%** as your portion of the covered charges for each hospital stay. This plan covers an unlimited number of additional inpatient hospital days. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive treatment/services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Customer Service. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please go to Chapter 5, section 2, How to ask us to pay you back or to pay a bill you have received. ▪ Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need.	

Services That Are Covered for You	What You Must Pay When You Get These Services
All other components of blood are also covered beginning with the first pint used. ▪ Physician services ***Note:*** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1 877 486 2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**In-Network:** For covered hospital stays: Days 1 - 6: **$260** copay per day, for each admission. Days 7 - 90: **$0** copay per day, for each admission. You do not pay a copay for additional inpatient mental health hospital days in an acute care general hospital. This plan covers an unlimited number of days in the psychiatric unit of an acute care general hospital. You have a 190 day lifetime limit for inpatient services in a psychiatric hospital. After the 190 day lifetime limit, you pay the remaining costs. Your provider must get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse or rehab. This is called getting prior authorization. **Out-of-Network:** For covered hospital stays:

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$500** yearly deductible, you pay **30%** as your portion of the covered charges for each hospital stay. You do not pay a copay for additional inpatient mental health hospital days in an acute care general hospital. This plan covers an unlimited number of days in the psychiatric unit of an acute care general hospital. You have a 190 day lifetime limit for inpatient services in a psychiatric hospital. After the 190 day lifetime limit, you pay the remaining costs. Providers not in our network should call the plan to determine coverage before elective inpatient admission. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay This plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached your SNF coverage limit, the plan will no longer cover your stay in the hospital or SNF. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: ▪ Physician services ▪ Diagnostic tests (like lab tests)	You must pay the full cost if you stay in a hospital or skilled nursing facility longer than your plan covers. If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this booklet.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ X-ray, radium, and isotope therapy including technician materials and services ▪ Surgical dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices ▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition ▪ Physical therapy, speech therapy, and occupational therapy	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each covered medical nutrition therapy visit. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-Network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for the MDPP benefit. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: ▪ Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug ▪ Antigens	**In-Network:** **20%** as your portion of the covered charges for chemotherapy and other drugs covered by Medicare Part B. Your provider must get an approval from the plan before you get certain injectable or infusible drugs. Call the plan to learn which drugs apply. This is called getting prior authorization. You still have to pay your portion of the cost allowed by the plan for a Part B drug whether you get it from a doctor's office or a pharmacy. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for chemotherapy and other drugs covered by Medicare Part B. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp® or Darbepoetin Alfa) ▪ Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	
Nurse HelpLine ▪ Nurse HelpLine: As a member, you have access to a 24-hour Nurse HelpLine, 7 days a week, 365 days a year. When you call our Nurse HelpLine, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the Nurse HelpLine at 1-855-658-9249. TTY users should call 711.	**$0** copay for the Nurse HelpLine.
 **Obesity screening and therapy to promote sustained weight loss** If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for preventive obesity screening and therapy. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: ▪ X-rays ▪ Radiation (radium and isotope) therapy including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Laboratory tests ▪ Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. ▪ Other outpatient diagnostic tests	**In-Network:** **$10** copay for each covered lab service. **$0** copay for hemoglobin A1c or urine tests to check albumin levels. **$75** copay for each covered diagnostic procedure or test in a provider's office or freestanding radiology center. **$150** copay for each covered diagnostic procedure or test in the outpatient department of a network hospital or facility. **$0** copay for tests to confirm chronic obstructive pulmonary disease (COPD). **$90** copay for each covered X-Ray in a provider's office or freestanding radiology center. **$110** copay for each covered X-Ray in the outpatient department of a network hospital or facility. **$130** copay for covered diagnostic radiology services in a provider's office or freestanding radiology center. **$150** copay for covered diagnostic radiology services in the outpatient department of a network hospital or facility. **20%** as your portion of the covered charges for each covered radiation therapy service. **$0** copay for covered blood, blood storage, processing and handling services. **20%** as your portion of the covered charges for surgical supplies, splints and casts. You may have to pay an additional cost for other services received during the visit. Your provider must get an approval from the plan before you get complex imaging or certain diagnostic and therapeutic radiology and lab services. This is called getting prior authorization. These include but are not limited to radiation therapy, PET, CT, SPECT, MRI scans, heart tests called

Services That Are Covered for You	What You Must Pay When You Get These Services
	echocardiograms, diagnostic lab tests, genetic testing, sleep studies and related equipment and supplies. All services must be coordinated by your Primary Care Provider (PCP). **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for lab services. Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for Hemoglobin A1c tests or urine tests to check Albumin levels. Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for each diagnostic procedure or test. Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for tests to confirm COPD. Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for covered diagnostic radiology services. Once you meet the **$500** yearly deductible, you pay **20%** as your portion of the covered charges for each covered radiation therapy service. Once you meet the **$500** yearly deductible, you pay **35%** as your portion of the covered charges for covered X-rays. Once you meet the **$500** yearly deductible, you pay **$0** copay for covered blood, blood storage, processing and handling services. Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for surgical supplies, splints and casts. You or your provider are encouraged to get prior approval from the plan for this service. Claims

Services That Are Covered for You	What You Must Pay When You Get These Services
	received without approval are subject to review and may include a medical necessity evaluation.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery ▪ Laboratory and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies such as splints and casts ▪ Certain drugs and biologicals that you can't give yourself ***Note:*** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1 877 486 2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**In-Network:** **$280** copay for each covered surgery or observation room service in an outpatient hospital. **$40** copay for each covered partial hospitalization visit for mental health or substance abuse. **20%** as your portion of the covered charges for medical supplies such as splints and casts. Additional copays or coinsurance may apply if other services are received during the same visit. All services must be coordinated by your Primary Care Provider (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **50%** as your portion of the covered charges for each surgical service or observation room service you get at an outpatient facility. Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each partial hospitalization visit for mental health or substance abuse. Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for medical supplies such as splints and casts. If medical supplies are billed as part of your outpatient hospital service, the outpatient hospital coinsurance will apply. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
	In- and Out-of-Network: Your cost share for emergency room visits, outpatient diagnostic tests, outpatient therapeutic services and lab tests are listed under those items elsewhere in this chart. Please see the Medicare Part B drugs section for details on certain drugs and biologicals. Look for the apple icon to learn about certain screenings and preventive care services.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-Network:** **$40** copay for each covered therapy visit. This applies to individual or group therapy. All services must be coordinated by your Primary Care Provider (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay a **$60** copay for each covered therapy visit. This applies to individual or group therapy. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network:** **$35** copay for each covered physical, occupational and speech language therapy visit. All services must be coordinated by your Primary Care Provider (PCP). Your provider must get an approval from the plan before you get physical, occupational and speech language therapy. This is called getting a prior

Services That Are Covered for You	What You Must Pay When You Get These Services
	authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **$60** copay for each covered physical, occupational and speech language therapy visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient substance abuse services Outpatient and ambulatory substance abuse treatment is supervised by an appropriate licensed professional. Outpatient treatment is provided for individuals or groups, and family therapy may be an additional component. Additional services may be covered in lieu of hospitalization, or as a step-down after hospitalization for substance abuse-related conditions.	**In-Network:** **$40** copay for each covered therapy visit. This applies to individual or group therapy. All services must be coordinated by your Primary Care Provider (PCP). Your provider must get an approval from the plan before you get intensive outpatient substance abuse services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the charges for each covered therapy visit. This applies to individual or group therapy. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers ***Note:*** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the	**In-Network:** **$230** copay for each covered surgery in an ambulatory surgical center. **$280** copay for each covered surgery or observation room service in an outpatient hospital.

Services That Are Covered for You	What You Must Pay When You Get These Services
provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	**$0** copay for a colon screening that includes a biopsy or removal of any growth or tissue when you get it at an outpatient or ambulatory surgical center. All services must be coordinated by your Primary Care Provider (PCP). Your provider must get an approval from the plan for select outpatient surgeries and procedures. This is called getting prior authorization. Additional copays or coinsurance may apply if other services are received during the same visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **50%** as your portion of the covered charges for each surgery in an ambulatory surgical center. Once you meet the **$500** yearly deductible, you pay **50%** as your portion of the covered charges for each surgery or observation room service in an outpatient hospital. Once you meet the **$500** yearly deductible, you pay **50%** as your portion of the covered charges for a screening exam of the colon that includes a biopsy or removal of any growth or tissue when you get it at an outpatient or ambulatory surgical center not in our network. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** **$40** copay for each covered partial hospitalization visit. Your provider must get an approval from the plan before each partial hospitalization for mental health or substance abuse. This is called getting prior authorization.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Out-of-Network: Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each covered partial hospitalization visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Physician/Practitioner services, including doctor's office visits Covered services include: ▪ Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment ▪ Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare ▪ Second opinion prior to surgery ▪ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	**In-Network:** **$10** copay for each covered Primary Care Provider (PCP) office visit. **$40** copay for each covered specialist office visit. **$10** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy. **$0** copay for each Medicare-covered dental visit for care that is not considered routine. **$40** copay for each covered hearing exam to diagnose a hearing condition. All services must be coordinated by your Primary Care Provider (PCP). Additional copays or coinsurance may apply if other services are received during the same visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay a **$40** copay for each covered PCP visit. Once you meet the **$500** yearly deductible, you pay a **$60** copay for each covered specialist visit. Once you meet the **$500** yearly deductible, you pay a **$40** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$500** yearly deductible, you pay **$0** copay for each Medicare-covered dental visit for care that is not considered routine. Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each covered hearing exam to diagnose a hearing condition. Additional copays or coinsurance may apply if other services are received during the same visit. Please get our approval before you get this care. This is called getting prior authorization. Claims we get without our prior approval may be reviewed for medical necessity.
Podiatry services - Medicare-covered Covered services include: ▪ Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). ▪ Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network:** **$40** copay for each Medicare-covered foot care visit. All services must be coordinated by your Primary Care Provider (PCP). Your provider may need to get an approval from the plan before you get these services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **$60** copay for each Medicare-covered foot care visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Podiatry services - Supplemental This plan covers additional foot care services not covered by Original Medicare. We cover: ▪ Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet	**In- and Out-of-Network:** Any costs you pay for routine podiatry care will not count toward your maximum out-of-pocket amount. This plan covers up to 6 supplemental foot care visits every year. **In-Network:** **$0** copay for each supplemental foot care visit. **Out-of-Network:**

Services That Are Covered for You	What You Must Pay When You Get These Services
	$60 copay for each supplemental foot care visit.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: ▪ Digital rectal exam ▪ Prostate Specific Antigen (PSA) test	**In-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each prostate cancer screening. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" later in this section for more detail.	**In-Network:** **20%** as your portion of the covered charges for covered prosthetic devices and supplies. You must get prosthetic devices and supplies from a supplier who works with this plan. They will not be covered if you buy them from a pharmacy. If you get a prosthetic or orthotic device while you are getting inpatient services at a hospital or skilled nursing facility, the cost will be included in your inpatient claim. Your provider must get an approval from the plan before you get prosthetic devices and the supplies that go with them. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for prosthetic devices, supplies and orthotics.

Services That Are Covered for You	What You Must Pay When You Get These Services
	You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**In-Network:** **$30** copay for each covered pulmonary rehabilitation visit. Your provider may need to get an approval from the plan before you get pulmonary rehabilitation services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each covered pulmonary rehabilitation visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for the screening and counseling to reduce alcohol misuse. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible members are: people aged 55 - 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for counseling and shared decision making visit or for the LDCT. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **In- and Out-of-Network:**

Services That Are Covered for You	What You Must Pay When You Get These Services
We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Services to treat kidney disease and conditions Covered services include: ▪ Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) ▪ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) ▪ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ▪ Home dialysis equipment and supplies ▪ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	**In-Network:** **$0** copay for each covered kidney disease education service visit. **20%** as your portion of the covered charges for: ▪ Kidney dialysis when you use a provider in our plan or you are out of the service area for a short time ▪ Dialysis equipment or supplies ▪ Dialysis home support services You pay the inpatient hospital member cost share for dialysis services that you receive while admitted to an inpatient hospital. **$0** copay for each covered training session to learn how to care for yourself if you need dialysis. You do not need to get an approval from the plan before getting dialysis. We ask that you let us know when you need to start this care so we can work with your providers. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the charges for each covered kidney disease education service visit. Once you meet the **$500** yearly deductible, you pay **20%** as your portion of the covered charges for kidney dialysis. You pay the inpatient hospital member cost share for dialysis services that you receive while admitted to an inpatient hospital.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$500** yearly deductible, you pay **20%** as your portion of charges for each covered training session to learn how to care for yourself if you need dialysis. Once you meet the **$500** yearly deductible, you pay **20%** as your portion of the covered charges for home support services and home dialysis equipment and supplies. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
SilverSneakers SilverSneakers® by Tivity Health The SilverSneakers fitness program is your fitness benefit. It includes: ▪ access to 13,000+ fitness locations ▪ use of exercise equipment ▪ group exercise classes designed for all levels and abilities ▪ a member website ▪ support all along the way SilverSneakers classes are offered in fitness locations' classrooms. More than 70 SilverSneakers FLEX® class options are offered in neighborhood locations. SilverSneakers FLEX classes include Latin dance, tai chi, yoga and walking groups. Three SilverSneakers BOOMT classes, MIND, MUSCLE and MOVE IT, offer more intense workouts inside the gym. All classes are led by certified instructors. To get started: Simply show your personal SilverSneakers ID number at the front desk of any SilverSneakers fitness location. Visit silversneakers.com to: ▪ get your SilverSneakers ID number ▪ find locations	**$0** copay for the SilverSneakers® Fitness Program.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ see class descriptions If you have questions, please call 1-888-423-4632 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. SilverSneakers is not just a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. The SilverSneakers fitness program is provided by Tivity Health, an independent company. Tivity Health, SilverSneakers, SilverSneakers BOOM and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. © 2017 Tivity Health, Inc. All rights reserved.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") 100 days per benefit period. No prior hospital stay required. Covered services include but are not limited to: ▪ Semiprivate room (or a private room if medically necessary) ▪ Meals, including special diets ▪ Skilled nursing services ▪ Physical therapy, occupational therapy, and speech therapy	**In-Network:** For covered SNF stays: Preferred participating SNF facilities: Days 1 - 20: **$0** copay per day Days 21 - 100: **$137.50** copay per day All other participating SNF facilities: Days 1 - 20: **$0** copay per day Days 21 - 100: **$167.50** copay per day Cost share is applied starting the day you are formally admitted as an inpatient in a Hospital or Skilled Nursing Facility. Cost share does not apply to the day you are discharged.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors) Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. ▪ Medical and surgical supplies ordinarily provided by SNFs ▪ Laboratory tests ordinarily provided by SNFs ▪ X-rays and other radiology services ordinarily provided by SNFs ▪ Use of appliances such as wheelchairs ordinarily provided by SNFs ▪ Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. ▪ A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) ▪ A SNF where your spouse is living at the time you leave the hospital	A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit on how many benefit periods you can have. Your provider must get approval from the plan before you get skilled nursing care. This is called getting prior authorization. The hospital should tell the plan within one business day of any emergency admission. **Out-of-Network:** For covered SNF stays: Once you meet the **$500** yearly deductible, you pay **50%** as your portion of the covered charges for each SNF stay. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for each smoking and tobacco use cessation.

Services That Are Covered for You	What You Must Pay When You Get These Services
counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Urgently needed service coverage is worldwide.	**In- and Out-of-Network:** **$35** copay for each covered urgently needed service. When you are outside the United States or its territories, this plan provides coverage for emergency/ urgent services only. This is a supplemental benefit and not a benefit covered under the Federal Medicare program. This benefit applies if you are traveling outside the United States for less than six months. This benefit is limited to **$25,000** per year for covered emergency/urgent services related to stabilize your condition. You are responsible for all costs that exceed **$25,000,** as well as all costs to return to your service area. You may have the option of purchasing additional travel insurance through an authorized agency. If you need urgent care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 800-810-BLUE or collect at 804-673-1177. Our representatives can help you 24 hours a day, 7 days a week, 365 days a year. **$80** copay for each covered worldwide urgently needed service.
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or	A maximum allowance of **$49** for each visit with a board-certified doctor. A maximum allowance of **$80** for each visit with a therapist and **$95** for each visit with a psychologist.

Services That Are Covered for You	What You Must Pay When You Get These Services
computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready - you'll need it to answer some questions. Sign up for Free: ▪ You must enter your health insurance information during enrollment, so have your member ID card ready when you sign up. Benefits of a video doctor visit: ▪ The visit is just like seeing your regular doctor face-to-face, but just by web camera. ▪ It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. ▪ The doctor can send prescriptions to the pharmacy of your choice, if needed[1]. ▪ If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and see a therapist or psychologist in four days or less[2]. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan. [1]Prescription is prescribed based on physician recommendations and state regulations (rules). LiveHealth Online is available in most states and is expected to grow more in the near future. Please see the map at livehealthonline.com for more service area details.	**In-Network:** **$0** copay for video doctor visits using LiveHealth Online. **Out-of-Network:** **$0** copay for video doctor visits. If you get a bill for more than the maximum allowed for covered services, you pay the difference between the provider's charge and the maximum allowed.

Services That Are Covered for You	What You Must Pay When You Get These Services
[2]Appointments are based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications.	
Vision care - Medicare-covered Covered services include: ▪ Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/ contacts ▪ For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older. ▪ For people with diabetes, screening for diabetic retinopathy is covered once per year ▪ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	**In-Network:** For Medicare-covered vision benefits, you must use a provider that is part of the Anthem MediBlue Access Core (PPO) specialty medical network. These providers can be located in the specialty section of the provider directory. For more information on benefits and providers, call Customer Service at the phone number printed on the back cover of this booklet. **$40** copay for each Medicare-covered exam to treat an eye condition. After you have covered cataract surgery, you pay a **$0** copay for one pair of Medicare-covered eyeglasses or contact lenses. Eye exams and early detection are important as some problems do not have symptoms. It matters to find problems early. Your doctor will tell you what tests you need. Talk to your doctor to see if you qualify. **$0** copay for a dilated retinal examination with a visual to check for things like Diabetic retinopathy for people with diabetes, macular degeneration, glaucoma and others. Your provider will bill with code 92004, 92227 or 92228. Your provider must include code 2022F to report the use of dilation during the exam. **$0** copay for a covered glaucoma test. This is a preventive test to see if you have increased pressure inside the eye that causes vision problems and the provider will bill as G0117 or G0118. Your medical vision benefit does not include a routine eye exam (refraction) for the purpose of prescribing glasses. If you have coverage under a supplemental benefit you will see that information below.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Additional copays or coinsurance may apply if other services are received during the same visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of covered charges for each Medicare-covered exam to treat an eye condition. Once you meet the **$500** yearly deductible, you pay a **$0** copay for one pair of Medicare-covered eye glasses or contact lenses after cataract surgery.
Vision care - Supplemental The plan covers additional vision coverage not covered by Original Medicare. We cover: ▪ Routine eye exam ▪ Eyewear (lenses and frames) ▪ Contact lenses	Please see Optional Supplemental Benefits located in Chapter 4 Section 2.2 for additional coverage options. We cover more vision care than what Medicare covers but you must go to a doctor in the Blue View Vision Insight network. You can find these doctors in the Blue View Vision Insight section of our Provider Directory. To learn more, call Customer Service at the phone number printed on the back cover of this booklet. You may have to pay more if you use an out-of-network provider. Any costs you pay for covered routine vision services will not count toward your maximum out-of-pocket amount. **In- and Out-of-Network:** This plan covers up to **$69** for 1 routine eye exam every calendar year. This plan will pay up to **$150** towards the purchase of eyewear (lenses, frames and/or contact lenses) every calendar year. Additional copays or coinsurance may apply if other services are received during the same visit. After the plan paid benefits are exhausted you are responsible for the remaining cost.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Benefits available under this plan cannot be combined with any other in-store discounts.
Visitor/Traveler The visitor/traveler program provides access to in-network level of benefits for plan covered services when you are traveling outside our service area for up to 12 months. Network and Service Area restrictions apply.	See Section 2.3 of this chapter for more detail.
 **"Welcome to Medicare" preventive visit** The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. ***Important:*** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. **Out-of-Network:** Once you meet the **$500** yearly deductible, you pay **40%** as your portion of the covered charges for the "Welcome to Medicare" preventive visit. **In- and Out-of-Network:** If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost-sharing for the care received for the existing medical condition or other services will also apply.

* Your Member Liability Calculation — the cost of the service, on which your member liability copayment/ coinsurance is based, will be either:

The Medicare allowable amount for covered services.
or

The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than or equal to the Medicare allowable amount.

Section 2.2

Extra "optional supplemental" benefits you can buy

Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called **"optional supplemental benefits."** If you want these optional supplemental benefits, you must sign up for them, and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

You may elect to enroll in an optional supplemental benefit package during the Annual Enrollment Period from October 15 through December 7. To enroll, call Customer Service, and ask for a *Short Enrollment Form*. Return the completed form to the address given on the form. You have the option of enrolling in these benefits up to 90 days after your effective date. Once you've enrolled, your optional supplemental benefits would become effective on the first of the following month.

You can pay your optional supplemental benefits monthly plan premium combined with your regular monthly plan premium or late-enrollment penalty, if you have one. The premium information provided in Chapter 1, Section 4 also applies to your optional supplemental benefits monthly premium, with one exception. As Chapter 1, Section 4 indicates, if you do not pay your regular plan premium or late-enrollment penalty, if you have one, we will send you a notice telling you that your plan membership will end if we do not receive your payment within 90 days. However, the grace period for your optional supplemental benefits is 60 days. Therefore, if you do not pay your premiums, your optional supplemental benefits will terminate after 60 days, and, if you have a regular premium or late-enrollment penalty, the rest of your benefits will terminate after 90 days.

If you are disenrolled due to nonpayment of premiums, you will not be able to re-enroll in an optional supplemental benefits package until the next Annual Enrollment Period.

If you decide you no longer want to be enrolled in an optional supplemental benefits package, send us a statement of your request. Please make sure to clarify that you do not want to disenroll from the Medicare Advantage plan, just the optional supplemental benefits portion. Your statement should include your name, Member ID and signature. Any premium overpayments will be applied to your regular monthly plan premium if you have one, or you can request to have the overpayment refunded to you. Once you have disenrolled from these benefits, you will not be able to re-enroll until the next Annual Enrollment Period.

The process for seeing in-network and out-of-network providers for your optional supplemental benefits is the same as it is for your other included benefits. See Chapter 3, Section 2 for more information on how to see in-network and out-of-network providers.

Optional supplemental benefits	What you must pay when you get these services
Optional supplemental package 1 – Preventive dental package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 1 – Preventive Dental Package.	
Premium	$21.00 monthly premium

Optional supplemental benefits	What you must pay when you get these services
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): ▪ D0120 – Periodic oral evaluation – established patient ▪ D0140 – Limited oral evaluation – problem focused ▪ D0150 – Comprehensive oral evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. ▪ D0210 – Intraoral – complete series (including bitewings) ▪ D0220 – Intraoral – periapical first radiographic image ▪ D0230 – Intraoral – periapical each additional radiographic image ▪ D0270 – Bitewings – single film ▪ D0272 – Bitewings – two films ▪ D0274 – Bitewings – four films ▪ D0330 – Panoramic film Two cleanings per year ▪ D1110 – Prophylaxis – adult Two fluoride treatments per year ▪ D1208 – Topical application of fluoride	**In- and Out-of-Network:** The plan will pay up to $500 for preventive dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **In-Network:** **You pay no copay** for the in-network preventive dental benefits listed. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim form for covered benefits. **Out-of-Network:** **You pay 20%** of the provider's charges as your portion for the preventive dental benefits listed when you do not use a LIBERTY Dental (Guardian) provider. **Exclusions & Limitations when rendered by in-network LIBERTY Dental (Guardian) providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. ▪ Restorative dental (fillings) and endodontic, periodontic and oral surgery services are excluded. ▪ Contracted LIBERTY Dental (Guardian) providers will bill the plan directly for covered services. However, out-of-network providers may require you to submit the

Optional supplemental benefits	What you must pay when you get these services
	claims directly to LIBERTY Dental (Guardian). ▪ Out-of-network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. ▪ Not all of the plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.
Optional supplemental package 2 – Dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 2 – Dental and Vision Package.	
Premium	$30.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): ▪ D0120 – Periodic oral evaluation – established patient ▪ D0140 – Limited oral evaluation – problem focused ▪ D0150 – Comprehensive oral evaluation – new or established patient ▪ D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year.	**In- and Out-of-Network:** The plan will pay up to $1,000 for dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **Preventive dental services** **In-Network:** **You pay no copay** for the in-network preventive dental benefits listed. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim form for covered benefits.

Optional supplemental benefits	What you must pay when you get these services
▪ D0210 – Intraoral – complete series (including bitewings) ▪ D0220 – Intraoral – periapical first radiographic image ▪ D0230 – Intraoral – periapical each additional radiographic image ▪ D0270 – Bitewings – single film ▪ D0272 – Bitewings – two films ▪ D0274 – Bitewings – four films ▪ D0330 – Panoramic film Two cleanings per year ▪ D1110 – Prophylaxis – adult Two fluoride treatments per year ▪ D1208 – Topical application of fluoride **Restorative dental services (fillings)** include the following procedures: ▪ D2140 – Amalgam – one surface, primary or permanent ▪ D2150 – Amalgam – two surfaces, primary or permanent ▪ D2160 – Amalgam – three surfaces, primary or permanent ▪ D2161 – Amalgam – four or more surfaces, primary or permanent ▪ D2330 – Resin-based composite – one surface, anterior ▪ D2331 – Resin-based composite – two surfaces, anterior ▪ D2332 – Resin-based composite – three surfaces, anterior ▪ D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior) ▪ D2391 – Resin-based composite – one surface, posterior ▪ D2392 – Resin-based composite – two surfaces, posterior ▪ D2393 – Resin-based composite – three surfaces, posterior ▪ D2394 – Resin-based composite – four or more surfaces, posterior **Endodontic, periodontic and oral surgery services** include the following procedures:	**Out-of-Network:** **You pay 30%** of the provider's charges as your portion for the preventive dental benefits listed when you do not use a LIBERTY Dental (Guardian) provider. **Restorative dental services (fillings)** **In-Network:** **You pay 20%** for in-network restorative dental services. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim form for covered benefits. **Out-of-Network:** **You pay 60%** of the Provider's charges as your portion for the restorative dental services listed when you do not use a LIBERTY Dental (Guardian) provider. **Endodontic, periodontic and oral surgery services** Endodontic, periodontic and oral surgery dental services include, but are not limited to, the following: ▪ Root canal treatment ▪ Periodontal scaling and root planing ▪ Simple and surgical extractions (limited to once per tooth per lifetime) **In-Network:** **You pay 50%** for in-network endodontic, periodontic and oral

Optional supplemental benefits	What you must pay when you get these services
▪ D7111 – Extraction, coronal remnants – deciduous tooth ▪ D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ▪ D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth ▪ D7220 – Removal of impacted tooth – soft tissue ▪ D7230 – Removal of impacted tooth – partially bony ▪ D7240 – Removal of impacted tooth – completely bony ▪ D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications ▪ D7250 – Surgical removal of residual tooth roots (cutting procedure) ▪ D3110 – Pulp cap – direct (excluding final restoration) ▪ D3120 – Pulp cap – indirect (excluding final restoration) ▪ D3220 – Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction & application of medicament ▪ D3221 – Pulpal debridement, primary & permanent teeth ▪ D3310 – Root canal – anterior (excluding final restoration) ▪ D3320 – Root canal – bicuspid (excluding final restoration) ▪ D3330 – Root canal – molar (excluding final restoration) ▪ D3346 – Retreatment of previous root canal therapy – anterior ▪ D3347 – Retreatment of previous root canal therapy – bicuspid ▪ D3348 – Retreatment of previous root canal therapy – molar ▪ D3351 – Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3353 – Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	surgery services. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim form for covered benefits. **Out-of-Network:** **You pay 75%** of the provider's charges as your portion for endodontic, periodontic and oral surgery services when you do not use a LIBERTY Dental (Guardian) provider. **Exclusions & Limitations when rendered by in-network LIBERTY Dental (Guardian) providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. ▪ Dentures and crowns are not covered under this package. ▪ Contracted LIBERTY Dental (Guardian) providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims to LIBERTY Dental (Guardian) directly. ▪ Out-of-network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. ▪ Not all of the Plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all

Optional supplemental benefits	What you must pay when you get these services
▪ D3410 – Apicoectomy/periradicular surgery – anterior ▪ D3421 – Apicoectomy/periradicular surgery – bicuspid (first root) ▪ D3425 – Apicoectomy/periradicular surgery – molar (first root) ▪ D3430 – Retrograde filling – per root ▪ D3450 – Root amputation – per root ▪ D3920 – Hemisection (including any root removal), not including root canal therapy ▪ D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4270 – Pedicle soft tissue graft procedure ▪ D4341 – Periodontal scaling & root planing – four or more teeth per quadrant ▪ D4342 – Periodontal scaling & root planing – one to three teeth per quadrant ▪ D4355 – Full mouth debridement to enable comprehensive evaluation & diagnosis ▪ D4910 – Periodontal maintenance	coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.

Optional supplemental benefits	What you must pay when you get these services
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: ▪ A routine eye exam is covered under your medical benefits once per calendar year. You must use a Blue View Vision Insight provider to receive the In-Network benefit. ▪ Post cataract surgery and associated eyewear is covered under your medical benefits.	**In- and Out-of-Network:** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. In-network coverage for eyewear benefits are vision services available only through Blue View Vision Insight network providers. Benefits available under this plan cannot be combined with any other in-store discounts. $150 reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating or non-participating provider. After the plan-paid benefits, the member is responsible for the remaining cost. When getting covered services from Blue View Vision Insight network providers, you will not need to submit a claim form. **Exclusions & limitations for this benefit package when rendered by in-network Blue View Vision Insight providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. ▪ Safety eyewear, non-prescription sunglasses, glass lenses,

Optional supplemental benefits	What you must pay when you get these services
	non-prescription lenses or contacts, or lens treatments are not covered. ▪ Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider directly for availability. ▪ Contracted Blue View Vision Insight providers will bill directly for covered services. However out-of-network providers may require you to submit the claims to Blue View Vision Insight directly. ▪ Not all of the Plan's medical providers are affiliated with Blue View Vision Insight. Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.
Optional supplemental package 3 – Enhanced dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 3 – Enhanced Dental and Vision Package.	
Premium	$42.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes):	**In-and Out-of-Network:** The plan will pay up to $1,500 for dental benefits each year (benefit maximum).

Optional supplemental benefits	What you must pay when you get these services
▪ D0120 – Periodic oral evaluation – established patient ▪ D0140 – Limited oral evaluation – problem focused ▪ D0150 – Comprehensive oral evaluation – new or established patient ▪ D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. ▪ D0210 – Intraoral – complete series (including bitewings) ▪ D0220 – Intraoral – periapical first radiographic image ▪ D0230 – Intraoral – periapical each additional radiographic image ▪ D0270 – Bitewings – single film ▪ D0272 – Bitewings – two films ▪ D0274 – Bitewings – four films ▪ D0330 – Panoramic film Two cleanings per year ▪ D1110 – Prophylaxis – adult Two fluoride treatments per year ▪ D1208 – Topical application of fluoride **Restorative dental (fillings)services** include the following procedures: ▪ D2140 – Amalgam – one surface, primary or permanent ▪ D2150 – Amalgam – two surfaces, primary or permanent ▪ D2160 – Amalgam – three surfaces, primary or permanent ▪ D2161 – Amalgam – four or more surfaces, primary or permanent ▪ D2330 – Resin-based composite – one surface, anterior ▪ D2331 – Resin-based composite – two surfaces, anterior	Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **Preventive dental services** **In-Network:** **You pay no copay** for in-network preventive dental benefits when using LIBERTY Dental (Guardian) providers. **Out-of-Network:** **You pay 30%** of the provider's charges as your portion for the preventive dental benefits listed when you do not use a LIBERTY Dental (Guardian) provider. **Restorative dental services (fillings)** **In-Network:** **You pay 20%** for in-network restorative dental services when using LIBERTY Dental (Guardian) providers. **Out-of-Network:** **You pay 60%** of the provider's charges as your portion for the restorative dental services listed when you do not use a LIBERTY Dental (Guardian) provider. **Endodontic, periodontic and oral surgery services** Endodontic, periodontic and oral surgery dental services include, but are not limited to, the following: ▪ Root canal treatment

Optional supplemental benefits	What you must pay when you get these services
▪ D2332 – Resin-based composite – three surfaces, anterior ▪ D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior) ▪ D2391 – Resin-based composite – one surface, posterior ▪ D2392 – Resin-based composite – two surfaces, posterior ▪ D2393 – Resin-based composite – three surfaces, posterior ▪ D2394 – Resin-based composite – four or more surfaces, posterior **Endodontic, periodontic, oral surgery, crowns, dentures, denture repair, relining, and rebasing, and anesthesia services** include the following procedures: ▪ D2740 – Crown – porcelain/ceramic substrate ▪ D2750 – Crown – porcelain fused to high noble metal ▪ D2751 – Crown – porcelain fused to predominantly base metal ▪ D2752 – Crown – porcelain fused to noble metal ▪ D2790 – Crown – full cast high noble metal ▪ D2791 – Crown – full cast predominantly base metal ▪ D2792 – Crown – full cast noble metal ▪ D2910 – Recement inlay, onlay, or partial coverage restoration ▪ D2915 – Recement cast or prefabricated post & core ▪ D2920 – Recement crown ▪ D2940 – Sedative filling ▪ D2950 – Core buildup, including any pins ▪ D2951 – Pin retention – per tooth, in addition to restoration ▪ D2952 – Post & core in addition to crown, indirectly fabricated ▪ D2954 – Prefabricated post & core in addition to crown ▪ D2955 – Post removal (not in conjunction with endodontic therapy)	▪ Periodontal scaling and root planing ▪ Simple and surgical extractions (limited to once per tooth per lifetime) **In-Network:** **You pay 50%** for in-network endodontic, periodontic and oral surgery services when using LIBERTY Dental (Guardian) providers. **Out-of-Network:** **You pay 75%** of the provider's charges as your portion for the endodontic, periodontic and oral surgery services when you do not use a LIBERTY Dental (Guardian) provider. **Exclusions & Limitations for this benefit package when rendered by in-network LIBERTY Dental (Guardian) providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. ▪ Contracted LIBERTY Dental (Guardian) providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims to LIBERTY Dental (Guardian) directly. ▪ Out-of-network services are reimbursed at usual and customary

Optional supplemental benefits	What you must pay when you get these services
▪ D3110 – Pulp cap – direct (excluding final restoration) ▪ D3120 – Pulp cap – indirect (excluding final restoration) ▪ D3220 – Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction & application of medicament ▪ D3221 – Pulpal debridement, primary & permanent teeth ▪ D3310 – Root canal – anterior (excluding final restoration) ▪ D3320 – Root canal – bicuspid (excluding final restoration) ▪ D3330 – Root canal – molar (excluding final restoration) ▪ D3346 – Retreatment of previous root canal therapy – anterior ▪ D3347 – Retreatment of previous root canal therapy – bicuspid ▪ D3348 – Retreatment of previous root canal therapy – molar ▪ D3351 – Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) ▪ D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3410 – Apicoectomy/periradicular surgery – anterior ▪ D3421 – Apicoectomy/periradicular surgery – bicuspid (first root) ▪ D3425 – Apicoectomy/periradicular surgery – molar (first root) ▪ D3430 – Retrograde filling – per root ▪ D3450 – Root amputation – per root ▪ D3920 – Hemisection (including any root removal), not including root canal therapy ▪ D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant	charges, which are not always billed charges by the provider. ▪ Not all of the plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.

Optional supplemental benefits	What you must pay when you get these services
▪ D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4270 – Pedicle soft tissue graft procedure ▪ D4341 – Periodontal scaling & root planing – four or more teeth per quadrant ▪ D4342 – Periodontal scaling & root planing – one to three teeth per quadrant ▪ D4355 – Full mouth debridement to enable comprehensive evaluation & diagnosis ▪ D4910 – Periodontal maintenance ▪ D5110 – Complete denture – maxillary ▪ D5120 – Complete denture – mandibular ▪ D5130 – Immediate denture – maxillary ▪ D5140 – Immediate denture – mandibular ▪ D5211 – Maxillary partial denture – resin base (including any conventional clasps, rests & teeth) ▪ D5212 – Mandibular partial denture – resin base (including any conventional clasps, rests & teeth) ▪ D5213 – Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth)	

Optional supplemental benefits	What you must pay when you get these services
▪ D5214 – Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth) ▪ D5421 – Adjust partial denture – maxillary ▪ D5422 – Adjust partial denture – mandibular ▪ D5510 – Repair broken complete denture base ▪ D5520 – Replace missing or broken teeth – complete denture (each tooth) ▪ D5610 – Repair resin denture base ▪ D5620 – Repair cast framework ▪ D5630 – Repair or replace broken clasp ▪ D5640 – Replace broken teeth – per tooth ▪ D5650 – Add tooth to existing partial denture ▪ D5660 – Add clasp to existing partial denture ▪ D5670 – Replace all teeth & acrylic on cast metal framework (maxillary) ▪ D5671 – Replace all teeth & acrylic on cast metal framework (mandibular) ▪ D5710 – Rebase complete maxillary denture ▪ D5711 – Rebase complete mandibular denture ▪ D5720 – Rebase maxillary partial denture ▪ D5721 – Rebase mandibular partial denture ▪ D5730 – Reline complete maxillary denture (chairside) ▪ D5731 – Reline complete mandibular denture (chairside) ▪ D5740 – Reline maxillary partial denture (chairside) ▪ D5741 – Reline mandibular partial denture (chairside) ▪ D5750 – Reline complete maxillary denture (laboratory) ▪ D5751 – Reline complete mandibular denture (laboratory)	

Optional supplemental benefits	What you must pay when you get these services
▪ D5760 – Reline maxillary partial denture (laboratory) ▪ D5761 – Reline mandibular partial denture (laboratory) ▪ D5850 – Tissue conditioning, maxillary ▪ D5851 – Tissue conditioning, mandibular ▪ D7111 – Extraction, coronal remnants – deciduous tooth ▪ D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ▪ D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth ▪ D7220 – Removal of impacted tooth – soft tissue ▪ D7230 – Removal of impacted tooth – partially bony ▪ D7240 – Removal of impacted tooth – completely bony ▪ D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications ▪ D7250 – Surgical removal of residual tooth roots (cutting procedure) ▪ D7260 – Orolantral fistula closure ▪ D7261 – Primary closure of a sinus perforation ▪ D7280 – Surgical access of an unerupted tooth ▪ D7282 – Mobilization of erupted or malpositioned tooth to aid eruption ▪ D7283 – Placement of device to facilitate eruption of impacted tooth ▪ D7285 – Biopsy of oral tissue – hard (bone, tooth) ▪ D7286 – Biopsy of oral tissue – soft ▪ D7287 – Exfoliative cytological sample collection ▪ D7288 – Brush biopsy – transepithelial sample collection ▪ D7310 – Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	

Optional supplemental benefits	What you must pay when you get these services
▪ D7311 – Alveoplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant ▪ D7320 – Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant ▪ D7321 – Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant ▪ D7410 – Excision of benign lesion of up to 1.25 Cm ▪ D7411 – Excision of benign lesion greater than 1.25 Cm ▪ D7412 – Excision of benign lesion, complicated ▪ D7450 – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 Cm ▪ D7451 – Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 Cm ▪ D7460 – Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 Cm ▪ D7461 – Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 Cm ▪ D7465 – Destruction of lesion(s) by physical or chemical method, by report ▪ D7510 – Incision and drainage of abscess – intraoral soft tissue ▪ D7511 – Incision and drainage of abscess – intraoral soft tissue –complicated (includes drainage of multiple facial spaces) ▪ D7520 – Incision and drainage of abscess – extraoral soft tissue ▪ D7521 – Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple facial spaces) ▪ D7530 – Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue ▪ D7540 – Removal of reaction-producing foreign bodies, muscoskeletal system ▪ D7960 – Frenulectomy (frenectomy or frenotomy) – separate procedure	

Optional supplemental benefits	What you must pay when you get these services
▪ D7963 – Frenuloplasty ▪ D9110 – Pallative treatment ▪ D9120 – Fixed partial denture sectioning ▪ D9210 – Local anesthesia not in conjunction with operative or surgical procedure ▪ D9211 – Regional block anesthesia ▪ D9212 – Trigeminal division block anesthesia ▪ D9215 – Local anesthesia ▪ D9220 – Deep sedation/general anesthesia – first 30 minutes ▪ D9221 – Deep sedation/general anesthesia – each additional 15 minutes ▪ D9230 – Analgesia, anxiolysis, inhalation of nitrous oxide ▪ D9241 – Intravenous conscious sedation/analgesia – first 30 minutes ▪ D9242 – Intravenous conscious sedation/analgesia each additional 15 minutes ▪ D9248 – Nonintravenous conscious sedation ▪ D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: ▪ A routine eye exam is covered under your medical benefits once per calendar year. You must use a Blue View Vision Insight provider to receive the In-Network benefit. ▪ Post cataract surgery and associated eyewear is covered under your medical benefits.	**In- and Out-of-Network:** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. In-network coverage for eyewear benefits are vision services available only through Blue View Vision Insight network providers. Benefits available under this plan cannot be combined with any other in-store discounts. $200 reimbursement allowance toward the purchase of eyewear. The benefit

Optional supplemental benefits	What you must pay when you get these services
	applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating or nonparticipating provider. After the plan-paid benefits, the member is responsible for the remaining cost. When getting covered services from Blue View Vision Insight network providers, you will not need to submit a claim form. **Exclusions & limitations for this benefit package when rendered by in-network Blue View Vision Insight providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. ▪ Safety eyewear, nonprescription sunglasses, glass lenses, nonprescription lenses or contacts, or lens treatments are not covered. ▪ Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider directly for availability. ▪ Contracted Blue View Vision Insight providers will bill directly for covered services. However, out-of-network providers may

Optional supplemental benefits	What you must pay when you get these services
	require you to submit the claims to Blue View Vision Insight directly. ▪ Not all of the Plan's medical providers are affiliated with Blue View Vision Insight. Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.

Section 2.3

Getting care using our plan's optional visitor/travel benefit

When you are continuously absent from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer as a supplemental benefit, a visitor/travel program, which will allow you to remain enrolled in our plan when you are outside of our service area for less than 12 months. This program is available to all Anthem MediBlue Access Core (PPO) members who are temporarily in the visitor/travel area. Under our visitor/travel program, you may receive all plan-covered services at in-network cost sharing. Please contact the plan for assistance in locating a provider when using the visitor/travel benefit.

If you are in the visitor/travel area, you can stay enrolled in our plan for up to 12 months. If you have not returned to the plan's service area within 12 months, you will be disenrolled from the plan.

The visitor/travel program provides your network level of benefits for most care covered by your plan when you're traveling outside the service area and go to Blue Medicare Advantage providers. These providers are located in 35 states and one territory: Alabama, Arkansas, California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Kentucky, Maine, Massachusetts, Michigan, Missouri, Montana, New Mexico, North Carolina, Nevada, New Hampshire, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, South Carolina, Tennessee, Texas, Utah, Virginia, Washington, Wisconsin and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

In addition, members may:

- Call your plan's Customer Service number found on the back cover of this booklet,
- Call 1-800-810-Blue to find a Blue Medicare Advantage PPO provider, or
- Visit the "Doctor & Hospital Finder" at https://shop.anthem.com/medicare to find a Blue Medicare Advantage PPO provider.

When you see Medicare Advantage PPO providers in any geographic area where the visitor/travel program is offered, you will pay the same cost-sharing level (in-network cost sharing) you would pay if you received covered benefits from in-network providers

in your service area. Please see the Medical Benefits Chart for cost-sharing information.

Section 3. What services are not covered by the plan?

Section 3.1

Services we do *not* cover (exclusions)

This section tells you what services are "excluded" from Medicare coverage and therefore, are not covered by this plan. If a service is "excluded," it means that this plan doesn't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found, upon appeal, to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

All exclusions or limitations on services are described in the Medical Benefits Chart, or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Fees for items and services reimbursable by other organizations or furnished without charge	✓	
Cosmetic surgery or procedures		✓ This may be covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Additionally, this is covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.		✓ Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. This plan may cover routine dental care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. To utilize this benefit you must use a provider who participates in our routine dental Vendor network. Please contact Customer Service to

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		locate a provider that is within that dental vendors network.
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Dental services are excluded from coverage in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for inpatient or outpatient hospital services required because of a medical condition. Additionally, some dental services are covered if an integral part of a covered medical procedure. Medicare has specific guidelines for covered services. Contact Customer Service for more information on these limited services.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered, if medically necessary and provided by a chiropractor or an other qualified provider. Medicare doesn't cover routine chiropractic care.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Medicare covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, heel spurs), but generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, flat foot, or hygienic or other preventive maintenance, including cleaning and soaking the feet). This plan may cover additional routine foot care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. To utilize

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		this benefit you must use a provider who participates in our routine podiatry provider network or your services will be considered out of network, even if rendered by a medical provider if they are not part of the Vendors network. Contact Customer Service for more information on these limited services.
Home-delivered meals	✓	
Orthopedic shoes		✓ Medicare has limited coverage for those who have diabetes and severe diabetic foot disease. If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. A podiatrist or other qualified doctor must prescribe these items. Modifications to shoes or inserts are not covered except when covered under Medicare guidelines.
Supportive devices for the feet		✓ Medicare has limited coverage for orthopedic or therapeutic shoes for people with diabetic foot disease. A podiatrist or other qualified doctor must prescribe these items. Modifications to shoes or inserts are not covered except when covered under Medicare guidelines.
Routine hearing exams, hearing aids, or exams to fit hearing aids.		✓ Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids. This plan may cover routine hearing care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. This plan may cover routine hearing care if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. To utilize this

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		benefit you must use a provider who participates in our routine hearing Vendor network Please contact Customer Service to locate a provider that is within that Hearing Vendors network or your services will be considered out of network, even if rendered by a medical provider if they are not part of the Vendors network.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, refraction vision tests, vision therapy and other low vision aids.		✓ Medicare doesn't cover routine eye exams, eyeglasses or contact lenses. However, an eye exam and one pair of eyeglasses (or contact lenses) are covered by Medicare for people after cataract surgery, that implants an intraocular lens. In addition to the Medicare coverage, this plan may cover routine eye exams and may cover routine eyewear if specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit or purchased as part of an optional supplemental benefit package. Refraction vision test are also not covered except where covered under supplemental routine eye exam benefit. This is a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine vision provider network or your services will be considered out of network, even if rendered by a medical provider if they are not part of the Vendors network.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	✓	
Acupuncture	✓	
Naturopath services (uses natural or alternative treatments).	✓	
Drugs for the treatment of sexual dysfunction, including erectile	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
dysfunction, impotence and anorgasmy or hyporgasmy.		
Over-the-counter purchases		✓ Medicare doesn't cover Over-the-counter purchases. This is considered excluded by statute or a benefit exclusion that is not covered under the Original Medicare program.
Wigs (even if needed due to a covered medical condition)	✓	
Providers who are prohibited from being covered under the Medicare program for any reason.	✓	
Worldwide Care		✓ Medicare generally doesn't cover health care while you're traveling outside the U.S. and its territories. There are some exceptions offered in limited circumstances as per Medicare guidelines. This plan may cover health care you get while traveling outside the U.S. if specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. This benefit applies to travel outside the United States and its territories for less than six months. Members are responsible for all costs that exceed the benefit limitation as well as all costs to return to the service area. If benefit available, coverage is limited to amount noted on benefit summary per year for all covered services rendered outside the US or its territories.
Prescription drugs you buy outside the U.S.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Services ordered or administered that are determined to not be a Medicare covered benefit in accordance with Medicare guidelines and the Social Security Act.		✓ Section 1833(e) of the Social Security Act prohibits Medicare payment for any request for coverage which lacks the necessary information to process the request. Section 1862(a)(1)(A)of the Social Security Act which excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.
Lab, Radiological & Genetic Testing		✓ We follow Medicare guidelines when determining if Lab, Radiological & Genetic Testing services are covered, even if ordered by a physician. Not all lab, Radiological or genetic testing is covered under the Medicare Program, such as Genetic testing based on family medical history. You have the right to contact the plan prior to services being rendered to determine if the services will be covered for your condition (see Organization Determination). When utilizing an out of network provider, you are not required to obtain prior authorization however are encouraged to do so. If no prior authorization is obtained we will review claims submitted to determine coverage under the Medicare program and you could be held liable if not covered.
Services performed by out-of-network providers.		✓ This plan covers services of out-of-network providers. You are responsible for verifying provider network status prior to receiving services. In-network providers and facilities are listed in the Provider Directory or online at www.anthem.com/medicare. The use of an out of network provider will apply the out of network provider cost share (even

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		approved) unless considered urgent/emergent (required immediately) or when approved in advance for in-network cost sharing. Please see Chapter 3, section 2.4 for more information. When utilizing an out of network provider, you are not required to obtain prior authorization however are encouraged to do so. If no prior authorization is obtained we will review claims submitted to determine coverage under the Medicare program and you could be held liable if not covered.
Services performed by non-participating vendor network providers		✓ Some supplemental benefits utilize a specific Vendor and providers who participate with that Vendor. Providers that participate with the plan may or may not be associated with that Vendor. You may call the plan prior to services being rendered with any questions. To be covered in network, you must use a provider that participates with that Vendor as identified in the provider directory or your services will be considered out of network, even if rendered by a medical provider if they are not part of the Vendors network. There may be other exceptions, see Chapter 3 (Using the plan's coverage for your medical services) for more information.
Non-emergency ambulance trips		✓ Medicare does not pay for transportation, including non-emergency ambulance transportation to and from dialysis, unless the Medicare definition of bed-confined is met and documented by your doctor. Bed-confined is defined as unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair.

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
Transportation (that Medicare does not cover such as trips to a physician's office) regardless of the member's condition.		✓ Medicare doesn't cover this service. This is considered excluded by statute or a benefit exclusion that is not covered under the Original Medicare program.
Modifications to a member's home such as a stair lift, bathtub grab bars or special pillows, chairs and other items that do not fall under Medicare-covered durable medical equipment	✓	
Items and services administered to a beneficiary for the purpose of causing or assisting in causing death.	✓	
Items and services required as a result of war	✓	
Items and Services authorized or paid by a government entity such as Veterans Administration authorized services	✓	
Defective equipment or medical devices covered under warranty	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

Chapter 5

Asking us to pay our share of a bill you have received for covered medical services

Chapter 5. Asking us to pay our share of a bill you have received for covered medical services

Section 1. Situations in which you should ask us to pay our share of the cost of your covered services

Section 1.1

If you pay our plan's share of the cost of your covered services, or, if you receive a bill, you can ask us for payment

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan.

In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

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

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times, you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute, and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.4.
- Whenever you get a bill from a network provider that you think is more than you should pay, send

us the bill. We will contact the provider directly and resolve the billing problem.

- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

Please call Customer Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has information about how to make an appeal.

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

Section 2.1

How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (to access the form, sign up at https://shop.anthem.com/medicare, log in, and locate the form under "Customer Support") or call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Mail your request for payment, together with any bills or receipts, to us at this address:

Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

You must submit your claim to us within 1 year of the date you received the service, item, or drug.

Contact Customer Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills, and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

Section 3. We will consider your request for payment and say yes or no

Section 3.1

We check to see whether we should cover the service and how much we owe

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

- If we decide that the medical care is covered, and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2

If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment, or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 7 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).* The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7.

Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read Section 4, you can go to Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

Chapter 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

Section 1. Our plan must honor your rights as a member of the plan

Section 1.1

We must provide information in a way that works for you (in languages other than English, in Braille, in large print or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in Braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with us at 1-855-690-7802 (TTY 711) or by writing us at: Civil Rights Coordinator, 4361 Irwin Simpson Rd, Mailstop: OH0205-A537; Mason, Ohio 45040. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Service (phone numbers are printed on the back cover of this booklet) for additional information.

Section 1.2

We must treat you with fairness and respect at all times

Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697), or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3

We must ensure that you get timely access to your covered services

You have the right to choose a provider in the plan's network. Call Customer Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care.

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this booklet tells what you can do. (If we have denied coverage for your medical care, and you don't agree with our decision, Chapter 7, Section 4 tells what you can do.)

Section 1.4

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Below is the Notice of Privacy Practices as of March 1, 2016. This Notice can change so to make sure you're viewing the most recent version, you can request the current version from Customer Service (phone numbers are printed on the back cover of this booklet) or view it on our website at https://shop.anthem.com/medicare.

Notices of privacy practices

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've

combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices
- HIPAA notice of privacy practices
- Breast reconstruction surgery benefits

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the Federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity.

You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you.

A more detailed state notice is available upon request. Please call the phone number printed on your membership card. Customer Service is available 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by Federal law to give you this notice.

Your protected health information

We may collect, use and share your Protected Health Information (PHI) for the following reasons, and others as allowed or required by law, including the HIPAA Privacy rule:

For payment: We use and share PHI to manage your account or benefits, or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations. For example, we may use PHI to review the quality of care and services you get.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital.

Examples of ways we use your information for payment, treatment and health care operations:

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share your explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.

- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations, and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit www.anthem.com/privacy for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing, first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide. You may tell us, in writing, that it is OK for us to give your PHI to someone else for any reason. Also, if you are present, and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities;
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents);
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety;
- Special government functions, for workers' compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

If you submit an online enrollment application for a Medicare Advantage, Medicare Advantage Part D or Part D Prescription Drug Plan, or, if an agent/broker submits it on your behalf, we record the Internet Protocol (IP) address the application is submitted from. We use this information in our efforts to prevent and detect fraud, waste and abuse in the Medicare program.

Authorization: We will get an OK from you, in writing, before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But, if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, ethnicity and language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information for various health care operations which include identifying health care disparities, developing care management programs and educational materials, and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting, rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your rights

Under Federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through email. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know, so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your membership card to use any of these rights. Customer Service is available 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.
- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we do not have to agree to a restriction (see the "Your Rights" section above). If a law requires the disclosure, we do not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic and procedural means. These safeguards follow Federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job.

Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your

written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the Federal privacy law) generally does not preempt or override other laws that give people greater privacy protections. As a result, if any state or Federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us.

You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your membership card. Customer Service is available 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time.

We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date of this Notice is March 1, 2016.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem Blue Cross and Blue Shield benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance. Contact Customer Service for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the Federal Department of Labor website at: dol.gov/ebsa/publications/whcra.html.

Section 1.5

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

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English, in Braille, large print, and other alternate formats.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network, and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider Directory.*
  - For more detailed information about our providers, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at https://shop.anthem.com/medicare.
- **Information about your coverage, and the rules you must follow when using your coverage.**
  - In Chapter 3 and Chapter 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or, if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy, or, if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.6

We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells how to ask the plan for a coverage decision.

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

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

This means that, *if you want to*, you can:

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

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

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

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

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

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

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate

against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Wisconsin Department of Health Services.

Section 1.7

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 1.8

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

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

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

Is it about something else?

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

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or you can **call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9

How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).

- You can **call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can **contact Medicare.**
  - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: https://www.medicare.gov/Pubs/pdf/11534.pdf.)
  - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 2. You have some responsibilities as a member of the plan

Section 2.1

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapter 3 and Chapter 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called **"coordination of benefits"** because it involves coordinating the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems, and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question, and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A, and most plan

members must pay a premium for Medicare Part B to remain a member of the plan.

- For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
- If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.

- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns**. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7

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

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Background

Coverage decisions and appeals

Making complaints

Background

Section 1. Introduction

Section 1.1

What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and appeals.**
- For other types of problems you need to use the **process for making complaints.**

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2

What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

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

Section 2. You can get help from government organizations that are not connected with us

Section 2.1

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP).** This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare.

Here are two ways to get information directly from Medicare:

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

Section 3. To deal with your problem, which process should you use?

Section 3.1

Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE:** **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which it is covered and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4, "A guide to the basics of coverage decisions and appeals."**	**No.** My problem is *not* about benefits or coverage. Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

Coverage decisions and appeals

Section 4. A guide to the basics of coverage decisions and appeals

Section 4.1

Asking for coverage decisions and making appeals: the big picture

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical services, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her, or, if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service, or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. (In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2

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

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically

forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3

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

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

- **Section 5** of this chapter: "Your medical care: how to ask for a coverage decision or make an appeal."
- **Section 6** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 7** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." (*Applies to these services only:* home health care, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section you should be using, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program. (Chapter 2, Section 3 of this booklet has the phone numbers for this program.)

Section 5. Your medical care: how to ask for a coverage decision or make an appeal

Have you read Section 4 of this chapter *(A guide to "the basics" of coverage decisions and appeals)?* If not, you may want to read it before you start this section.

Section 5.1

This section tells what to do if you have problems getting coverage for medical care, or, if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved, will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- Note: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
  - Chapter 7, Section 6: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
  - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?	
If you are in this situation:	**This is what you can do:**
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2.**
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal.** (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2

Step-by-step: how to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)

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

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

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

How to request coverage for the medical care you want

- Start by calling, writing or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally, we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines, unless we have agreed to use the "fast" deadlines. **A standard coverage decision means we will give you an answer within 14 calendar days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or, if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

If your health requires it, ask us to give you a "fast coverage decision"

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or, if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a fast complaint about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor tells us that your health requires a "fast coverage decision", we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 72 hours (or, if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or, if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we

extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3

Step-by-step: how to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."**

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do

- **To start an appeal, you, your doctor or your representative must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal, in writing, by submitting a request.**
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing, or call us** at the phone number shown in Chapter 2, Section 1 *(How to contact us when you are making an appeal about your medical care).*
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include, if you had a serious illness that prevented you from contacting us, or, if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**

- You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
- If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

Legal Terms A "fast appeal" is also called an **"expedited reconsideration."**

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

Step 2: We consider your appeal, and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or, if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal, if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or, if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast

complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4

Step-by-step: how a Level 2 Appeal is done

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the "**IRE.**"

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision, in writing, and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision" you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down, and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 8 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 5.5

What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services.* Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*).

We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services).*

We will say yes or no to your request

- If the medical care you paid for is covered, and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying yes to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment, and we say that we will not pay?

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Section 6. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your **"discharge date."**
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered. This section tells you how to ask.

Section 6.1

During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message From Medicare About Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted

to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date.) Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html.

Section 6.2

Step-by-step: how to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government

organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received, *An (Important Message From Medicare About Your Rights)* tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4 of this booklet.)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date, *without paying for it,* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review"

You must ask the Quality Improvement Organization for a **"fast review"** of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines.

Legal Terms A **"fast review"** is also called an **"immediate review"** or an **"expedited review."**

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains, in detail, the reasons why your doctor, the hospital and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms This written explanation is called the "**Detailed Notice of Discharge.**" You can get a sample of this notice by calling Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal, and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3

Step-by-step: how to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs, and coverage limitations may apply.

If the review organization says no

- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing, what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 6.4

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-step: how to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, an **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the "**IRE.**"

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse, or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing, what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal.) If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 7. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1

This section is about three services only: home health care, skilled nursing facility care and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words.*)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words.*)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay).*

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you

in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

Section 7.2

We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing**. At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)
The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does *not* mean you agree** with the plan that it's time to stop getting the care.

Section 7.3

Step-by-step: how to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4 of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal, *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms This notice of explanation is called the **"Detailed Explanation of Non-Coverage."**

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (See Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you**. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – *and* you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4

Step-by-step: how to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal, *and* you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you, in writing, what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3, and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 7.5

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most).

If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-step: how to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your medical care.*
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we told you, and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-step: Level 2 *Alternate* Appeal Process

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms The formal name for the "Independent Review Organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you, in writing, what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3, and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 8. Taking your Appeal to Level 3 and beyond

Section 8.1

Levels of Appeal 3, 4 and 5 for medical service appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal

A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **If the administrative law judge says yes to your appeal, the appeals process *may* or *may not* be over**. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the administrative law judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you

what to do next if you choose to continue with your appeal.

Level 4 Appeal

The **Appeals Council** will review your appeal and give you an answer. The Appeals Council works for the Federal government.

- **If the answer is yes, or, if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no, or, if the Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Making complaints

Section 9. How to make a complaint about quality of care, waiting times, Customer Service or other concerns

If your problem is about decisions related to benefits, coverage or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Complaint	Example
Quality of your medical care	▪ Are you unhappy with the quality of the care you have received (including care in the hospital)?

Complaint	Example
Respecting your privacy	▪ Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	▪ Has someone been rude or disrespectful to you? ▪ Are you unhappy with how our Customer Service has treated you? ▪ Do you feel you are being encouraged to leave the plan?
Waiting times	▪ Are you having trouble getting an appointment, or waiting too long to get it? ▪ Have you been kept waiting too long by doctors, or other health professionals? Or by our Customer Service or other staff at the plan? – Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	▪ Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	▪ Do you believe we have not given you a notice that we are required to give? ▪ Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: ▪ If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. ▪ If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.

Complaint	Example
	▪ When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. ▪ When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2

The formal name for "making a complaint" is "filing a grievance"

Legal Terms What this section calls a **"complaint"** is also called a **"grievance."**

Another term for **"making a complaint"** is **"filing a grievance."**

Another way to say **"using the process for complaints"** is **"using the process for filing a grievance."**

Section 9.3

Step-by-step: making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step**. If there is anything else you need to do, Customer Service will let you know. You can call Customer Service from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30 at 1-855-690-7802. (TTY: 711)
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
  - You or someone you name may file a grievance. The person you name would be your representative. You may name a relative, friend, lawyer, advocate, doctor or anyone else to act for you.
  - If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.
  - A grievance must be filed, either verbally or in writing, within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or, if we justify a need for additional information, and the delay is in your best interest.
  - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or, if we take an

extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.

- **Whether you call or write, you should contact Customer Service right away**. The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint."** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest, or, if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received, to us, by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received, directly to this organization (*without* making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
  - To find the name, address and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4 of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us, and also to the Quality Improvement Organization.

Section 9.5

You can also tell Medicare about your complaint

You can submit a complaint about Anthem MediBlue Access Core (PPO) directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this

information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or, if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

Section 1. Introduction

Section 1.1

This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

Section 2. When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1

You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2

You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period.**

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3

In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples. For the full list you can contact the plan, call Medicare or visit the Medicare website (https://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term-care (LTC) hospital.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
  - Original Medicare *with* a separate Medicare prescription drug plan;
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4

Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2018*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (https://www.medicare.gov).

Or, you can order a printed copy by calling Medicare at the number below.

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

Section 3. How do you end your membership in our plan?

Section 3.1

Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods. (See Section 2 in this chapter for information about the enrollment periods.)

However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- *--or--* You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
▪ Another Medicare health plan	▪ Enroll in the new Medicare health plan. ▪ You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *with* a separate Medicare prescription drug plan	▪ Enroll in the new Medicare prescription drug plan. ▪ You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *without* a separate Medicare prescription drug plan	▪ **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). ▪ You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. ▪ You will be disenrolled from our plan when your coverage in Original Medicare begins.

Section 4. Until your membership ends, you must keep getting your medical services through our plan

Section 4.1

Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.)

During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

Section 5. Anthem MediBlue Access Core (PPO) must end your membership in the plan in certain situations

Section 5.1

When must we end your membership in the plan?

Our plan must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
  - Go to Chapter 4, Section 2.3 for information on getting care, when you are away from the service area, through our plan's visitor/travel benefit.
  - If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 60 days.
  - We must notify you, in writing, that you have 60 days to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2

We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3

You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons, in writing, for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9

Legal notices

Chapter 9. Legal notices

Section 1. Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities, even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Section 2. Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Section 3. Notice about Medicare secondary payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Anthem MediBlue Access Core (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4. Additional legal notices

Collecting member payments

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

In the event that a service is rendered for which you are billed, you have at least 12 months from the date of service to submit such claims to your plan. According to CMS Pub 100-02 Benefit Policy, Chapter 15, Section 40, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they **are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.** However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services.

You may submit such claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Entire contract

This *Evidence of Coverage* and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of Anthem Blue Cross and Blue Shield, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart in Chapter 4.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Cessation of operation

In the event of the cessation of operation or dissolution of your plan in the area in which you reside, this *Evidence of Coverage* will be terminated. You will receive notice 90 days before the *Evidence of Coverage* is terminated.

Please note: If the *Evidence of Coverage* terminates, your coverage will also end.

In that event, the company will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, Anthem Blue Cross and Blue Shield would arrange for you to obtain, without health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles. Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure, and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than three years after the service upon which the legal action is based was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a non-network provider instead of a network provider. Your plan will reimburse you up to the amount that would have been covered under this *Evidence of Coverage*.

- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

The plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*.

This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service at 1-855-690-7802 or, if you are hearing or speech impaired and have a TTY telephone line, 711. The Customer Service department is available from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. The plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions)

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both - to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 2 of this booklet tells how to contact your SHIP. SHIPs have different names depending on which state you are in.

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

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

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Anthem Blue Cross and Blue Shield has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, Anthem Blue Cross and Blue Shield helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.
- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the “made whole” doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident or incident, resulting in personal injury or illness to you, occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate

with us, do whatever is necessary to enable us to exercise our rights, and do nothing to prejudice our rights.

- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits We have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

Presidential or Gubernatorial emergencies

In the event of a Presidential or Gubernatorial emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, your plan will make the following exceptions to assure adequate care during the emergency:

- Approve services to be furnished at specified non-contracted facilities that are considered a Medicare-certified facility;
- Temporarily reduce cost sharing for plan-approved out-of-network services to the in-network cost-sharing amounts; and
- Waive in full the requirements for a primary physician referral where applicable.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and, if CMS has not indicated an end date to the disaster or emergency, your plan will resume normal operations 30 days from the initial declaration.

When a disaster or emergency is declared, it is specific to a geographic location (i.e., county). Your plan will apply the above exceptions only if you reside in the geographic location indicated.

Chapter 10

Definitions of important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Combined maximum out-of-pocket amount – This is the most you will pay, in a year, for all Part A and Part B services from both network (preferred) providers and out-of-network (nonpreferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay")– An amount you may be required to pay, as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: 1) any deductible amount a plan may impose before services are covered; 2) any

fixed "copayment" amount that a plan requires when a specific service is received; or 3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered services – The general term we use, in this *Evidence of Coverage*, to mean all of the health care services and supplies that are covered by our plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department, within our plan, responsible for answering your questions about your membership, benefits, grievances and appeals. See Chapter 2 for information about how to contact Customer Service.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable medical equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate or stabilize an emergency medical condition.

Evidence of Coverage **(EOC) and disclosure information** – This document, along with your enrollment form and any other attachments, riders or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Grievance – A type of complaint you make about us , including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay

premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital inpatient stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-month period that begins three months before the month you turn 65, includes the month you turn 65 and ends three months after the month you turn 65.

In-network maximum out-of-pocket amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (nonpreferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Low-Income Subsidy (LIS) – See "Extra Help"

Medicaid (or medical assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2018.

Medicare Advantage (MA) plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage plans with prescription drug coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with end-stage renal disease (unless certain exceptions apply).

Medicare-covered services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare health plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare prescription drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies, to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers"** when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers, or, if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("traditional Medicare" or "fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-pocket costs – See the definition for "Cost Sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

Part C – See "Medicare Advantage (MA) plan."

Part D – The voluntary Medicare prescription drug benefit program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred)

providers, and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company or a health care plan for health and/or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about primary care providers.

Prior authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us.

Prosthetics and orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Rehabilitation services – These services include physical therapy, speech and language therapy and occupational therapy.

Service area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled nursing facility (SNF) care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or, if we violate our contract with you.

Special needs plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by

out-of-network providers when network providers are temporarily unavailable or inaccessible.

Anthem MediBlue Access Core (PPO) Customer Service – contact information

Call: 1-855-690-7802. Calls to this number are free. From October 1 through February 14, Customer Service representatives will be available to answer your call directly from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. From February 15 through September 30, Customer Service representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. Our automated system is available any time for self-service options. You can also leave a message after hours and on weekends and holidays. Please leave your phone number and the other information requested by our automated system. A representative will return your call by the end of the next business day.

Customer Service also has free language interpreter services available for non-English speakers.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

Fax: 1-877-664-1504

Write: Anthem Blue Cross and Blue Shield Customer Service
P.O. Box 105187
Atlanta, GA 30348-5187

Website: https://shop.anthem.com/medicare

State Health Insurance Program

State Health Insurance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare.

In Wisconsin:

Wisconsin SHIP (SHIP) - contact information

Call: 1-800-242-1060

TTY: 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: Wisconsin SHIP (SHIP)
One West Wilson St.
Madison, WI 53703

Website: https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

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