Evidence of Coverage

Effective January 1, 2024

Anthem Medicare Preferred (PPO) plan

Preferred Provider Organization (PPO)

Anthem

Contracted by the CalPERS Board of Administration Under
the Public Employees' Medical & Hospital Care Act (PEMHCA)

CalPERS

EVIDENCE OF COVERAGE

January 1, 2024 – December 31, 2024

Your Group-Sponsored Medicare Health Benefits and Services as a Member of Anthem Medicare Preferred (PPO)

This document gives you the details about your Medicare health care coverage from January 1, 2024 – December 31, 2024. **This is an important legal document. Please keep it in a safe place**.

For questions about this document, please contact Member Services at **1-855-251-8825**. (TTY users should call **711**.) Hours are Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays. This call is free.

This plan, Anthem Medicare Preferred (PPO), is offered by Anthem BC Health Insurance Company. When this *Evidence of Coverage* says "we," "us" or "our," it means Anthem BC Health Insurance Company. When it says "the plan," "our plan" or "your plan," it means Anthem Medicare Preferred (PPO). When it says "you" or "your" it means you, or your covered spouse or domestic partner, and/or covered dependent(s).

Our plan has free language interpreter services available to answer questions from non-English speaking members. Please call the Member Services number listed above to request interpreter services.

This document may be available in alternate formats. Please call the Member Services number listed above for additional information.

The provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your cost sharing;
- Your medical benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)

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YOUR BENEFITS CHART

In addition to your medical benefits, this chart includes information on supplemental benefits, services and discounts

 **Look for the apple!**
It shows a preventive service.

Your 2024 Medical Benefits Chart
PPO Plan 10PH
CalPERS

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Doctor and hospital choice You may go to doctors, specialists, and hospitals in or out of the network. You do not need a referral.		
Prior authorization* Benefit categories that include services that require prior authorization are marked with an asterisk (*). Additional information can be found on the last page of the medical benefits chart.		
Annual deductible • The deductible applies to covered services as noted within each category below, prior to the copay or coinsurance, if any, being applied.	$0 Combined in-network and out-of-network	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient services		
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 doctor's order. The day before you are discharged is your last inpatient day. 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 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 therapy, occupational therapy, and speech language therapy • Inpatient substance abuse services • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care)	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) • 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 are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If 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 a 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. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines. • Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood begins with the first pint. • Physician services		If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient hospital care (con't) In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center. **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, 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 www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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, seven days a week.		
Inpatient services in a psychiatric hospital* Covered services include mental health care services that require a hospital stay in a psychiatric hospital or the psychiatric unit of a general hospital. In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan. $0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care*	For Medicare-covered SNF stays:	For Medicare-covered SNF stays:
(For a definition of skilled nursing facility, see the Definition of important words chapter in your Evidence of coverage (EOC).)	$0 copay for days 1-100 per benefit period	$0 copay for days 1-100 per benefit period
Inpatient skilled nursing facility (SNF) coverage is limited to 100 days each benefit period. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a SNF. The benefit period ends when you have not been an inpatient at any hospital or SNF for 60 days in a row.	No prior hospital stay required.	No prior hospital stay required.
Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech language therapy • 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, packed red cells, and all other components of blood begins with the first pint. • 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		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Skilled nursing facility (SNF) care (con't) Generally, you will receive your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan 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 or domestic partner is living at the time you leave the hospital In-network providers should notify us within one business day of any planned, and if possible, unplanned admissions or transfers, including to or from a hospital, skilled nursing facility, long term acute care hospital, or acute rehabilitation center.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Inpatient services covered when the hospital or SNF days are not covered or are no longer covered*	After your SNF day limits are used up, this plan will still pay for covered physician services and other medical services outlined in this benefits chart at the cost share amounts indicated.	
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 a skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Prosthetic and orthotic 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, occupational therapy, and speech language therapy		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
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 eight hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech language therapy • Medical and social services • Medical equipment and supplies	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.	$0 copay for Medicare-covered home health visits Durable Medical Equipment (DME) copay or coinsurance, if any, may apply.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Hospice care 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 six months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be an in-network provider or an out-of-network provider. 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 this plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. Services covered by Original Medicare include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, nonurgently 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 and follow plan rules (such as if there is a requirement to obtain prior authorization).	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $10 copay for the one time only hospice consultation	You must receive care from a Medicare-certified hospice. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and B services are paid for by Original Medicare, not this plan. $10 copay for the one time only hospice consultation

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Hospice care (con't) • If you obtain the covered services from an in-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 this plan but are not covered by Medicare Part A or B: This plan will continue to cover plan-covered services that are not 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. If you have Part D prescription drug coverage, some drugs may be covered under your Part D benefit. Drugs are never covered by both hospice and your Part D plan at the same time. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient services		
Physician services, including doctor's office visits*	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services	$10 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services
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 • Retail health clinics • Basic hearing and balance exams performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment • Telehealth services for some physician or mental health services can be found in the section of this benefit chart titled, Video doctor visits • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location	$10 copay per visit to an in-network specialist for Medicare-covered services $10 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing	$10 copay per visit to an out-of-network specialist for Medicare-covered services $10 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Physician services, including doctor's office visits (con't) • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ○ You have an in-person visit within six months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if: ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past seven days **and** ○ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past seven days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, internet, or electronic health record • Second opinion by another in-network provider prior to surgery • Physician services rendered in the home • Outpatient hospital services	$0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Physician services, including doctor's office visits (con't) • In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. • Allergy testing and allergy injections		
Chiropractic services* • We cover only manual manipulation of the spine to correct subluxation.	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain* Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • Nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, disease, etc.); • Not associated with surgery; and • Not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have:	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Acupuncture for chronic low back pain (con't) • A masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • A current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27.		
Podiatry services* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and disease of the feet (such as hammer toe or heel spurs), in an office setting • Medicare-covered routine foot care for members with certain medical conditions affecting the lower limbs • A foot exam covered every six months for people with diabetic peripheral neuropathy and loss of protective sensations	$10 copay for each Medicare-covered visit	$10 copay for each Medicare-covered visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient mental health care, including partial hospitalization services*		
Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws	$10 copay for each Medicare-covered professional individual therapy visit	$10 copay for each Medicare-covered professional individual therapy visit
	$10 copay for each Medicare-covered professional group therapy visit	$10 copay for each Medicare-covered professional group therapy visit
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	$10 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient substance abuse services, including partial hospitalization services*		
Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	$10 copay for each Medicare-covered professional individual therapy visit	$10 copay for each Medicare-covered professional individual therapy visit
	$10 copay for each Medicare-covered professional group therapy visit	$10 copay for each Medicare-covered professional group therapy visit
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization.	$10 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit	$10 copay for each Medicare-covered professional partial hospitalization and intensive outpatient services visit
	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit	$0 copay for each Medicare-covered outpatient hospital facility individual therapy visit
	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit	$0 copay for each Medicare-covered outpatient hospital facility group therapy visit
	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit	$0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* Facilities where surgical procedures are performed and the patient is released the same day. **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the 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. 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 www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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, seven days a week.	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit	$0 copay for each Medicare-covered outpatient hospital facility or ambulatory surgical center visit for surgery $0 copay for each Medicare-covered outpatient observation room visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient hospital observation, non-surgical Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you 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 **www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.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, seven days a week.	$10 copay for a visit to an in-network primary care physician in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $10 copay for a visit to an in-network specialist in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit	$10 copay for a visit to an out-of-network primary care physician in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $10 copay for a visit to an out-of-network specialist in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Ambulance services • Covered ambulance services, whether for an emergency or nonemergency situation, include fixed wing, rotary wing, water, and ground ambulance services, to the nearest appropriate facility that can provide care only if the services 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. • If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. • Ambulance service is not covered for physician office visits.	Your provider must get an approval from the plan before you get ground, air, or water transportation that is not an emergency. $0 copay per one-way trip for Medicare-covered ambulance services	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. Emergency outpatient copay is waived if the member is admitted to the hospital within 72 hours for the same condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), 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. This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. If you receive authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.	$50 copay for each Medicare-covered emergency room visit	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Urgently needed services • Urgently needed services are available on a worldwide basis. The urgently needed services copay is waived if the member is admitted to the hospital within 72 hours for the same condition. If you are outside of the service area for your plan, your plan covers urgently needed services, including urgently required renal dialysis. Urgently needed services are services provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care but, given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers. If it is unreasonable given your circumstances to immediately obtain the medical care from a network provider, then your plan will cover the urgently needed services from a provider out-of-network. Services must be immediately needed and medically necessary. Examples of urgently needed services that the plan must cover out of network occur if: You are temporarily outside the service area of the plan and require medically needed immediate services for an unforeseen condition, but it is not a medical emergency; or it is unreasonable given your circumstances to immediately obtain the medical care from a network provider. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	$25 copay for each Medicare-covered urgently needed care visit	
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).	$10 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits	$10 copay for Medicare-covered physical therapy, occupational therapy, and speech language therapy visits

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
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.	$0 copay for Medicare-covered cardiac rehabilitation therapy visits	$0 copay for Medicare-covered cardiac rehabilitation therapy visits
Pulmonary rehabilitation services* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	$10 copay for Medicare-covered pulmonary rehabilitation therapy visits	$10 copay for Medicare-covered pulmonary rehabilitation therapy visits
Supervised exercise therapy (SET)* SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	$10 copay for Medicare-covered supervised exercise therapy visits	$10 copay for Medicare-covered supervised exercise therapy visits

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Durable medical equipment (DME) and related supplies*	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen
(For a definition of durable medical equipment, see the Definition of important words chapter in your EOC.)		
Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, continuous blood glucose monitors, hospital bed ordered by a provider for use at home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.		
For additional information on the ownership of DME and the rental of oxygen supplies and oxygen, please see Chapter 3.	The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes.	The rental period for oxygen equipment and oxygen is 36 months. For the remaining 24 months you will be responsible for the oxygen. After the five-year period, the cost-sharing responsibility for both oxygen supplies and oxygen resumes.
Copay or coinsurance only applies when you are not currently receiving inpatient care. If you are receiving inpatient care your DME will be included in the copay or coinsurance for those services.		
We cover all medically necessary durable medical equipment 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.		
Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines.	$0 copay for Medicare-covered CGMs and related supplies	$0 copay for Medicare-covered CGMs and related supplies
Coverage is limited to three sensors per month and one receiver every two years.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.	See the Diabetes self-management training, diabetic services, and supplies benefit section for diabetic supply cost sharing.
This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids (HA). Other brands are covered if deemed medically necessary by the provider. The review of medical necessity for use of HA and any non-preferred brands is part of the plan's prior authorization process.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Prosthetic devices and related supplies* Devices (other than dental) that replace all or 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.	10% coinsurance for Medicare-covered prosthetics and orthotics	10% coinsurance for Medicare-covered prosthetics and orthotics
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the home infusion therapy professional services, home infusion requires a durable medical equipment component: • Durable medical equipment – the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)	$0 copay for Medicare-covered professional services provided by a qualified home infusion supplier in the patient's home 10% coinsurance for Medicare-covered durable medical equipment – includes the external infusion pump, the related supplies, and the infusion drug(s)

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
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 • Blood glucose monitors are limited to one every year • Up to 200 blood glucose test strips and lancets for a 30-day supply • One pair per year of therapeutic custom molded shoes (including inserts provided with such shoes) and two additional pairs of inserts or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes) for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Diabetes self-management training is covered under certain conditions	**If purchased through a pharmacy:** $0 copay for a 30-day supply on each Medicare-covered purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips, lancets, lancet devices, and glucose control solutions or a $10 copay for all other brands when purchased through the pharmacy **If purchased through a pharmacy:** $0 copay for Medicare-covered OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose monitors or a $10 copay for all other brands when purchased through the pharmacy	**If purchased through a pharmacy:** $0 copay for a 30-day supply on each Medicare-covered purchase of OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips, lancets, lancet devices, and glucose control solutions or a $10 copay for all other brands when purchased through the pharmacy **If purchased through a pharmacy:** $0 copay for Medicare-covered OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose monitors or a $10 copay for all other brands when purchased through the pharmacy

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies (con't)	**If purchased through a DME provider:** $0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions when purchased through a DME provider **If purchased through a DME provider:** $0 copay for Medicare-covered blood glucose monitors when purchased through a DME provider $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training	**If purchased through a DME provider:** $0 copay for a 30-day supply on each Medicare-covered purchase of blood glucose test strips, lancets, lancet devices, and glucose control solutions when purchased through a DME provider **If purchased through a DME provider:** $0 copay for Medicare-covered blood glucose monitors when purchased through a DME provider $0 copay for Medicare-covered therapeutic shoes and inserts $0 copay for Medicare-covered diabetes self-management training

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Diabetes self-management training, diabetic services, and supplies (con't)	See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.	See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Outpatient diagnostic tests and therapeutic services and supplies*	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test
Covered services include, but are not limited to: • X-rays • Complex diagnostic tests and radiology services • Radiation (radium and isotope) therapy, including technician materials and supplies • Testing to confirm chronic obstructive pulmonary disease (COPD) • 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, packed red cells, and all other components of blood begins with the first pint • Other outpatient diagnostic tests Certain diagnostic tests and radiology services are considered complex and include heart catheterizations, sleep studies, computed tomography (CT), magnetic resonance procedures (MRIs and MRAs), and nuclear medicine studies, which includes PET scans.	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood	$0 copay for Medicare-covered complex diagnostic test and/or radiology visit $0 copay for each Medicare-covered radiation therapy treatment $0 copay for Medicare-covered testing to confirm chronic obstructive pulmonary disease 10% coinsurance for Medicare-covered supplies $0 copay for each Medicare-covered clinical/diagnostic lab test $0 copay per Medicare-covered pint of blood

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Opioid treatment program services* Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments	$10 copay per visit for Medicare-covered opioid treatment program services	$10 copay per visit for Medicare-covered opioid treatment program services

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Vision care (non-routine) 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 age 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.)	$10 copay for visits to an in-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $10 copay for visits to an in-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/ contacts following Medicare-covered cataract surgery	$10 copay for visits to an out-of-network primary care physician for Medicare-covered exams to diagnose and treat diseases of the eye $10 copay for visits to an out-of-network specialist for Medicare-covered exams to diagnose and treat diseases of the eye $0 copay for Medicare-covered glaucoma screening $0 copay for Medicare-covered diabetic retinopathy screening 20% coinsurance for glasses/ contacts following Medicare-covered cataract surgery

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Preventive services care and screening tests  You will see this apple next to preventive services throughout this chart. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you in-network. However, if you are treated or monitored for an existing medical condition or an additional non-preventive service, during the visit when you receive the preventive service, a copay or coinsurance may apply for that care received. In addition, if an office visit is billed for the existing medical condition care or an additional non-preventive service received, the applicable in-network primary care physician or in-network specialist copay or coinsurance will apply.		
 **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.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.	There is no coinsurance, copayment, or deductible for members eligible for this Medicare-covered preventive screening.
 **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 bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Barium enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium enema as an alternative to flexible sigmoidoscopy for patient not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal services: • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.	There is no coinsurance, copayment, or deductible for the Medicare-covered colorectal cancer screening exam and services.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Colorectal cancer screening and colorectal services (con't) Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.		
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	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for members eligible for the Medicare-covered preventive HIV screening.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B immunizations Covered services include: • Pneumonia vaccine • Flu shots, including H1N1, once each flu season in the fall and winter, with additional flu shots if medically necessary • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine • Other vaccines if you are at risk and they meet Medicare Part B coverage rules **If you have Part D prescription drug coverage, some vaccines are covered under your Part D benefit (for example, the shingles vaccine). Please refer to your Part D prescription drug benefits.**	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, Hepatitis B, COVID-19, or other Medicare-covered vaccines when you are at risk and they meet Medicare Part B rules.
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 aged 40 and older • Clinical breast exams once every 24 months	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.	There is no coinsurance, copayment, or deductible for Medicare-covered screening mammograms.
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 three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Prostate cancer screening exams For men aged 50 and older, the following are covered once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual PSA test.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered intensive behavioral therapy cardiovascular disease preventive benefit.
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).	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.	There is no coinsurance, copayment, or deductible for Medicare-covered cardiovascular disease testing that is covered once every five years.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Welcome to Medicare preventive visit The plan covers a one-time Welcome to Medicare preventive visit. The visit includes a review of your health, measurements of height, weight, body mass index, blood pressure, 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered Welcome to Medicare preventive visit.
Annual wellness visit If you've had Medicare 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 preventive visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.	There is no coinsurance, copayment, or deductible for the Medicare-covered annual wellness visit.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.	There is no coinsurance, copayment, or deductible for a Medicare-covered annual depression screening visit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
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.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.	There is no coinsurance, copayment, or deductible for Medicare-covered diabetes screening tests.
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.	There is no coinsurance, copayment, or deductible for the MDPP benefit.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive obesity screening and therapy.
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.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 50 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 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 enrollee 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.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor. We cover three 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 two 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 referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another plan year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Smoking and tobacco use cessation (counseling to quit smoking) 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. Each 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. Each counseling attempt includes up to four face-to-face visits. These visits must be ordered by your doctor and provided by a qualified doctor or other Medicare-recognized practitioner.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Other services		
Services to treat outpatient kidney disease 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 or when your provider for this service is temporarily unavailable or inaccessible) • Home dialysis or 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) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home and outpatient dialysis equipment and supplies 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 below, Medicare Part B prescription drugs.	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $10 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies	You do not need to get an approval from the plan before getting dialysis. But please let us know when you need to start this care, so we can help coordinate with your doctors. $0 copay for each Medicare-covered kidney disease education session $10 copay for Medicare-covered outpatient dialysis $0 copay for Medicare-covered home dialysis or home support services $10 copay for Medicare-covered self-dialysis training 10% coinsurance for Medicare-covered home dialysis equipment and supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Services to treat outpatient kidney disease (con't)	10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs)*	20% coinsurance for Medicare-covered Part B drugs	20% coinsurance for Medicare-covered Part B 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:	20% coinsurance for Medicare-covered Part B drug administration	20% coinsurance for Medicare-covered Part B drug administration
• Drugs include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically-necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by 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 • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents such as Erythropoietin (Epogen®), Procrit®, or Epoetin Alfa, and Darbepoetin Alfa (Aranesp®)	Certain rebatable drugs may be subject to a lower coinsurance. 20% coinsurance with a maximum out-of-pocket of $35 for a Medicare-covered one-month supply of insulin 20% coinsurance for Medicare-covered Part B chemotherapy drugs	Certain rebatable drugs may be subject to a lower coinsurance. 20% coinsurance with a maximum out-of-pocket of $35 for a Medicare-covered one-month supply of insulin 20% coinsurance for Medicare-covered Part B chemotherapy drugs

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Part B prescription drugs covered under your medical plan (Part B drugs) (con't) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Part B prescription drug benefit. Some of Part B covered drugs listed above may be subject to step therapy. You may log into your secure member portal to find the list of Part B drugs that may be subject to step therapy. This list is located with your Plan Documents under your Benefits section. **If you have Part D prescription drug coverage, please refer to your *Evidence of Coverage* for information on your Part D prescription drug benefits.**	20% coinsurance for Medicare-covered Part B chemotherapy drug administration	20% coinsurance for Medicare-covered Part B chemotherapy drug administration

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Additional supplemental benefits, services, and discounts		
Routine hearing services • Routine hearing exams are limited to one every 12 months • Hearing aid fitting evaluations are limited to one per covered hearing aid Routine hearing exams and fitting evaluations are limited to a $70 maximum benefit every 12 months combined in-network and out-of-network. Hearing aids Hearing aids are limited to a $1,000 maximum benefit every 36 months through Hearing Care Solutions. The maximum benefit coverage amount applies to covered, prescribed hearing aids. Includes digital hearing aid technology and inner ear, outer ear, and over the ear models. Fitting adjustment after hearing aid is received, if necessary. The hearing aid benefit does not provide coverage for over-the-counter hearing aids, amplifiers, internet purchases, over the phone purchases, assistive listening devices (ALDs), disposable hearing aids, earmolds or accessories. We have partnered with Hearing Care Solutions to bring you these discounts and services. Although you can see an out-of-network provider for your exam, you must select a hearing aid from the list available through Hearing Care Solutions. They will send the hearing aid(s) directly to your provider. Hearing Aids must be supplied by the plan's hearing network vendor, Hearing Care Solutions. The plan does not reimburse for devices received from other vendors or providers under this supplemental benefit.	Must use a Hearing Care Solutions participating provider. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids	Out-of-network providers must order hearing aids through Hearing Care Solutions. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids through Hearing Care Solutions Hearing aid must be ordered through Hearing Care Solutions and selected from the list of available devices. Hearing Care Solutions will send the device directly to your provider.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine hearing services (con't) For more information on your benefit, covered devices or to locate a Hearing Care Solutions provider please contact Hearing Care Solutions at **1-855-312-2545**. Hearing benefit management administered by Hearing Care Solutions, an independent company.	Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.	Members receive a free battery supply for non-rechargeable hearing aids during the first three years with a 64-cell limit per year, per hearing aid. After the plan pays benefits for routine hearing exams, hearing aids, and hearing aid fitting evaluations, you are responsible for any remaining cost.
Routine vision services • Routine vision exams Routine vision exams are limited to one every calendar year. This is a primary vision care benefit intended to cover only routine eye examinations. Blue View Vision is for routine eye care only. If you need medical treatment for your eyes, visit a participating eye care doctor from your medical network. This information is intended to be a brief outline of coverage. For additional benefit information, including exclusions and limitations or to locate a participating Blue View Vision provider, please contact Member Services. If you choose to, you may instead receive covered benefits outside of the Blue View Vision network. Just pay in full at the time of service, obtain an itemized receipt and file a claim for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply.	Must use a Blue View Vision provider. $10 copay for routine vision exams, including refraction After the plan pays benefits for routine vision exams, you are responsible for any remaining cost.	$10 copay for routine vision exams, including refraction After the plan pays benefits for routine vision exams, you are responsible for any remaining cost.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine foot care • Up to 12 covered visits per year combined in-network and out-of-network Routine foot care includes the cutting or removal of corns and calluses, the trimming, cutting, clipping or debriding of nails, and other hygienic and preventive maintenance care.	$10 copay for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.	$10 copay for each routine foot care visit After the plan pays benefits for routine foot care, you are responsible for any remaining cost.
Annual routine physical exam The annual routine physical exam benefit covers a standard physical exam in addition to the Medicare-covered Welcome to Medicare or Annual Wellness Visit.	$0 copay for an annual physical exam	$0 copay for an annual physical exam

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Video doctor visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists and psychiatrists through live, two-way video on your smartphone, tablet or 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 plan membership 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 plan membership 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 talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care.	$0 copay for video doctor visits using LiveHealth Online	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Video doctor visits (con't) 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). 2. Appointments are typically scheduled within seven days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. 3. Appointments are typically scheduled within 28 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Health and wellness education programs **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations[1]. You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks, and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On Demand videos and the SilverSneakers GO mobile app. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call **1-888-423-4632 (TTY: 711)** Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. 1. Participating locations (PL) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. 2. Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2021 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	$0 copay for the SilverSneakers fitness benefit	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
24/7 NurseLine Also, as a member, you have access to a 24-hour nurse line, seven days a week, 365 days a year. When you call our nurse line, 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 line at **1-800-700-9184**. TTY users should call **711**. Only 24/7 NurseLine is included in our plan. All other nurse access programs are excluded.	$0 copay for 24/7 NurseLine	
Foreign travel emergency and urgently needed services Emergency or urgently needed care services while traveling outside the United States or its territories during a temporary absence of less than six months. Outpatient copay is waived if member is admitted to hospital within 72 hours for the same condition. • Emergency outpatient care • Urgently needed services • Inpatient care (60 days per lifetime) This coverage is worldwide and is limited to what is allowed under the Medicare fee schedule for the services performed/ received in the United States. If you are in need of emergency care outside of the United States or its territories, you should call the Blue Cross Blue Shield Global Core Program at **800-810-BLUE** or collect at **804-673-1177**. Representatives are available 24 hours a day, seven days a week, 365 days a year to assist you. 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. For more coverage, you may have the option of purchasing additional travel insurance through an authorized agency.	$50 copay for emergency care $25 copay for urgently needed services $0 copay per admission for emergency inpatient care	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare Community Resource Support Need help with a specific issue? Your plan benefits are designed to cover what Medicare covers, as well as some additional supplemental benefits as described in this benefits chart, but we know that you might need additional help. As a member, your plan provides a Medicare Community Resource Support benefit to help bridge the gap between your medical benefits and your optimal health, by connecting you to resources available to you in your community. The Medicare Education and Outreach team can help you locate helpful resources within your community, such as food pantries, home maintenance programs, utility assistance programs, social activities, and much more. If you need assistance or have questions about this benefit, call Member Services at the number listed on the back of your plan membership card.	$0 copay for Medicare Community Resource Support	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Healthy Meals*	$0 copay for Healthy Meals	
Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home or when you have a Body Mass Index (BMI) of 18.5 or under, you have a BMI of 25 or higher or an A1C level more than 9.0 as determined by your provider. • This benefit also qualifies as a Special Supplemental Benefit for the Chronically Ill (SSBCI). To receive meals as a Special Supplemental Benefit for the Chronically Ill, you must: ○ Meet the CMS mandated criteria, which may include providing supporting information from you or at times your physician. This criteria can be found in the Chapter Medical benefits (what is covered and what you pay) in your *Evidence of Coverage*. You can contact Member Services on the back of your plan membership card to begin the process to validate your eligibility. Under most circumstances, we are unable to initiate your benefit without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
In-home support • This benefit provides up to 30 hours of companionship and assistance with independent activities of daily living, such as home-based chores, help getting to appointments or getting items such as groceries, medication, and more. Help getting to appointments does not include transportation. • In-home support can work in conjunction with other benefits or care plans to promote independent living, aid in reducing a member's feeling of social isolation and improve their overall mental outlook. • You must use a plan approved provider. For more information about this benefit please contact Member Services.	$0 copay for in-home support	
Personal emergency response system (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the plan with our contracted vendor. The personal emergency response system benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). For more information about this benefit or to request the unit please call Member Services.	$0 copay for personal emergency response system	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Routine transportation • Routine transportation covers up to 12 one-way trips each year. A trip is defined as a ride from one destination to another. A trip is limited to 60 miles. • Trips are covered within your local service area for plan covered services, such as medical visits, visits to SilverSneakers locations and visits to a pharmacy to pick up prescriptions. A stop at a pharmacy after a doctor's appointment to pick up prescriptions will not count as a separate trip. When you schedule a pick-up from the visit, tell the vendor that you need to go to the pharmacy. Ask the provider/facility to call in the prescription so you have a shorter wait. • You must schedule trips 48 hours (excluding weekends) in advance. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. • Trips will not be covered for non-health related services such as going to buy groceries, personal errands or other reasons when accessing non-covered services. We have partnered with Access2Care to bring you these discounts and services. For more information about this benefit please contact Member Services. Access2Care, an independent company is providing routine transportation on behalf of our plan.	$0 copay for routine transportation	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Additional acupuncture services* Coverage includes acupuncture services, not covered by Medicare, rendered by a licensed acupuncturist to treat a disease, illness or injury. Benefits include: • Initial patient exam, as well as acupuncture treatment, re-examinations and other services in various combinations Medicare non-covered acupuncture services and Medicare non-covered chiropractic services, combined, are limited to 20 visits per year combined in-network and out-of-network. For additional benefit information, please contact Member Services.	$10 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services and Medicare non-covered chiropractic services, you are responsible for any remaining cost.	$10 copay per visit After the plan pays benefits for Medicare non-covered acupuncture services and Medicare non-covered chiropractic services, you are responsible for any remaining cost.
Additional chiropractic services* Coverage includes chiropractic services, not covered by Medicare, rendered by a physician to treat a disease, illness or injury. Benefits include: • Diagnostic services, other than diagnostic scanning, when provided during an initial examination or re-examination; • Adjustments; • Radiological x-rays and laboratory tests; and • Medically necessary therapy when provided in conjunction with the visit specifically for spinal or joint adjustment. Medicare non-covered chiropractic services and Medicare non-covered acupuncture services, combined, are limited to 20 visits per year combined in-network and out-of-network. For additional benefit information, please contact Member Services.	$10 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services and Medicare non-covered acupuncture services, you are responsible for any remaining cost.	$10 copay per visit After the plan pays benefits for Medicare non-covered chiropractic services and Medicare non-covered acupuncture services, you are responsible for any remaining cost.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
Medicare-approved clinical research studies A clinical research study 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. If you participate in a Medicare-approved study, Original Medicare pays the doctors and other providers for the covered services you receive as part of the study. Although not required, we ask that you notify us if you participate in a Medicare-approved research study.	After Original Medicare has paid its share of the Medicare-approved study, this plan will pay the difference between what Medicare has paid and this plan's cost sharing for like services. Any remaining plan cost sharing you are responsible for will accrue toward this plan's out-of-pocket maximum.	
Annual out-of-pocket maximum All copays, coinsurance, and deductibles listed in this benefits chart are accrued toward the medical plan out-of-pocket maximum with the exception of routine hearing services, routine vision services, and the foreign travel emergency and urgently needed services copay or coinsurance amounts. Part D prescription drug deductibles and copays do not apply to the medical plan out-of-pocket maximum.	$1,500 Combined in-network and out-of-network	

* Some services that fall within this benefit category require prior authorization. Based on the service you are receiving, your provider will know if prior authorization is needed. This means an approval in advance is needed, by your plan, to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-network provider gets prior authorization from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, we recommend you ask for a pre-visit coverage decision to confirm that the services you are getting are covered and medically necessary. Benefit categories that include services that require prior authorization are marked with an asterisk in the benefits chart.

Note: While you can get your care from an out-of-network provider for Medicare-covered services, 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. Providers that do not contract with us are under no obligation to treat you, except in emergency situations.

CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Anthem Medicare Preferred (PPO), which is a group-sponsored Medicare PPO plan

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Anthem Medicare Preferred (PPO). We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ from Original Medicare.

Anthem Medicare Preferred (PPO) is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company. This plan does not include Part D prescription drug coverage.

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

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document explains how to get your medical care. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of Anthem Medicare Preferred (PPO).

It's important for you to learn what your 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* document.

If you are confused, concerned or just have a question, please contact Member Services.

Section 1.3 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how your 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 benefits described in this *Evidence of Coverage* are in effect during the months listed on the first page, as long as you are a validly enrolled member in this plan.

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 your plan after December 31, 2024, or on your group-sponsored plan's renewal date. We can also choose to stop offering the plan in your service area, after December 31, 2024.

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue each year 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 Medicare Part B.
- - *and* - you live in our geographic service area. Section 2.3 below describes our service area. Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- - *and* - you are a United States citizen or are lawfully present in the United States.
- - *and* - you are eligible for coverage under your group-sponsored health plan retiree benefits.

If you have questions regarding your eligibility for coverage under your group-sponsored retiree benefits, please contact the group sponsor.

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 physicians' services, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the service area for our plan

Our plan is available only to individuals who live in our geographic service area. To remain a member of our plan, you must continue to reside in our plan service area. The service area is described below:

Our CMS-defined geographic service area includes all 50 states, Washington, D.C., Puerto Rico, Guam, U.S. Virgin Islands, American Samoa and Northern Mariana Islands.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact all of the following to update your contact information:

- Member Services.
- Group sponsor of your group plan.
- Social Security. You can find their phone numbers and contact information in Chapter 2, Section 5.

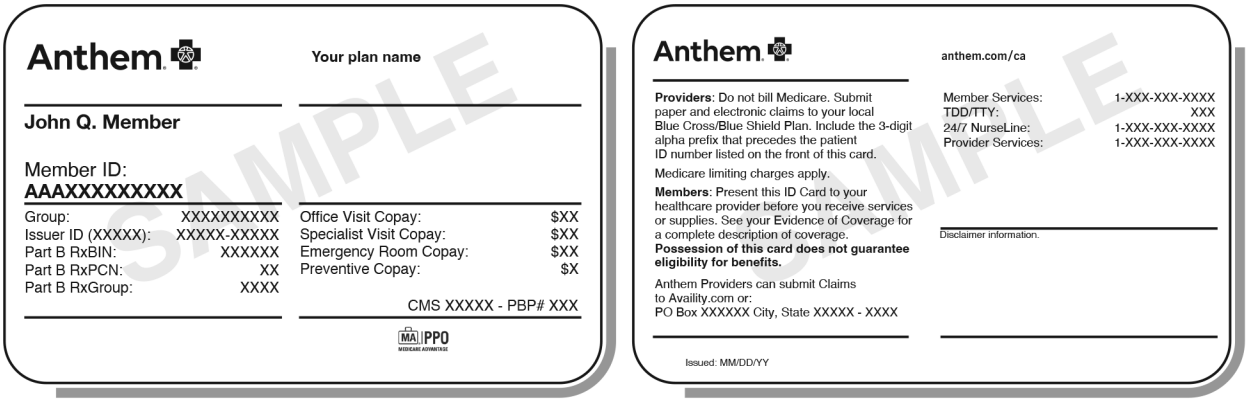
Section 2.4 U.S. citizen or lawful presence

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 Medicare Preferred (PPO) if you are not eligible to remain a member on this basis. Anthem Medicare Preferred (PPO) must disenroll you if you do not meet this requirement.

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your plan membership card whenever you get services covered by this plan. Here's a sample plan membership card to show you what yours will look like:



Do NOT use your red, white and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your plan membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare approved clinical research studies also called clinical trials.

If your plan membership card is damaged, lost or stolen, call Member Services right away and we will send you a new card. You can also log into **www.anthem.com/ca/calpers** to print temporary plan membership cards.

Section 3.2 *Provider Directory*

This Anthem Medicare Preferred (PPO) plan allows you to see a provider you choose who accepts Medicare and our plan as an out-of-network provider. Your cost share is the same for in- or out-of-network providers.

The *Provider Directory* lists our current in-network providers and durable medical equipment (DME) suppliers. In-network providers are the doctors and other health care professionals, medical groups, DME 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. See Chapter 3, "Using the plan for your medical services," and Chapter 4, "Medical benefits (what is covered and what you pay)," for more specific information.

Please note: While you can get your care from an out-of-network provider, the provider must be enrolled and 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 enrolled and eligible to participate in Medicare.

If you don't have your copy of the *Provider Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider Directories will be mailed to you within three business days.

How do you locate a provider?

To locate an in-network provider, you should:

- Call your plan's Member Services phone number on the back cover of this document
- Visit "Find Care" on our website or
- Call **1-800-810-Blue** (**1-800-810-2583**)

1. If you are in an area without access to in-network providers, designated as a non-network county, you can use out-of-network providers who participate with Medicare.
2. If you are currently using providers who participate with Medicare, you should first inform your current providers that:
    - You are enrolled under a new plan.
    - Although the new plan is a PPO, you can continue to be seen by them if they agree.
3. If the provider elects not to provide services, you can self-refer to another provider that participates with Medicare.
4. If you are unable to find a provider, please contact Member Services, who will:
    - Respond with at least one provider of the requested provider type(s) within a reasonable travel distance.
    - Respond within 72 hours for standard requests for a provider.
    - Respond on the same day for urgent care services (medical services to be furnished within 12 hours in order to avoid the likely onset of an emergency medical condition).

Please note: Independent laboratory and specialty pharmacy claims are submitted to the plan based on the location of your referring/ordering provider. The independent lab and specialty pharmacy network status is determined based on the plan's service area for the referring provider. Durable medical equipment (DME) and supplies claims are submitted to the plan based on the location where the item is shipped to (your residence), or the location where the item was purchased from a retail store. The DME network status is determined based on the plan's service area for the location where the item was shipped to or where the item was purchased from a retail store.

SECTION 4 Your monthly costs

Section 4.1 Plan premium

Your coverage is provided through a contract with your group sponsor. Please contact your group sponsor to get information on any plan premium amounts for which you may be responsible. Or, if you are billed directly by your plan, please contact Member Services.

Section 4.2 Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums.

You must continue paying your Medicare premiums to remain a member of the plan. This includes your premium for Part B. It may also include a premium for Part A which affects members who aren't eligible for premium free Part A.

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called "2024 Medicare Costs." If you need a copy you can download it from the Medicare website (**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 4.3 Can we change your monthly plan premium during the year?

Generally, your plan premium won't change during the benefit year. You will be notified in advance if there will be any changes for the next benefit year in your plan premium.

SECTION 5 Keeping your plan membership record up to date

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

The doctors, hospitals and other providers need to have the correct information about you. **These 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 group sponsor, your spouse or domestic partner'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 (Note: You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so).

If any of this information changes, please let us know by calling Member Services. Please remember to also notify your group sponsor of your group plan so they will have your most up-to-date contact information on file.

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.

SECTION 6 How other insurance works with our plan

Other insurance

Medicare requires that we collect information from you about any other medical insurance coverage that you have in addition to this retiree coverage. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical 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 Member Services. 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.

When you have other insurance, there are rules set by Medicare that decide which of your insurance plans pays first, and which pays second or even third. 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. If you have other insurance, tell your doctor, hospital, and pharmacy.

If you have another group-sponsored health plan in addition to this plan, the following rules will be used to determine whether this retiree coverage or your other coverage pays first:

- If you have retiree coverage, Medicare pays first.
- If your group-sponsored health plan coverage is based on your current employment or a family member's current employment, who pays first depends on your age, the number of people employed by your group-sponsored plan, 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 plan pays first if the group has 100 or more employees or at least one group in a multiple group-sponsored plan that has more than 100 employees.
    - If you're over 65 and you or your spouse or domestic partner is still working, your plan pays first if the group has 20 or more employees or at least one group in a multiple group-sponsored plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group-sponsored 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, group-sponsored health plans, and/or Medigap have paid.

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Your plan contacts (how to contact us, including how to reach Member Services)

How to contact our plan's Member Services

For assistance, please call or write to Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	**1-855-251-8825** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services 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.
FAX	**1-844-470-8861**
WRITE	Anthem Medicare Preferred (PPO) P.O. Box 173144 Denver, CO 80217-3144
WEBSITE	**www.anthem.com/ca/calpers**

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)."

You only need to request a coverage decision, submit an appeal or a complaint once.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	**1-855-251-8825** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays

Method	Coverage Decisions for Medical Care – Contact Information
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.
FAX	**1-844-470-8861**
WRITE	Anthem Medicare Preferred (PPO) P.O. Box 173144 Denver, CO 80217-3144
WEBSITE	**www.anthem.com/ca/calpers**

Method	Appeals for Medical Care – Contact Information
CALL	**1-855-251-8825** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
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.
FAX	**1-888-458-1406**
WRITE	Anthem BC Health Insurance Company Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	**www.anthem.com/ca/calpers**

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 in-network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. 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)."

Method	Complaints about Medical Care – Contact Information
CALL	**1-855-251-8825** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays
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.
FAX	**1-888-458-1406**
WRITE	Anthem BC Health Insurance Company Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
MEDICARE WEBSITE	You can submit a complaint about your plan directly to Medicare. To submit an online complaint to Medicare, go to **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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask your plan for reimbursement or to pay the provider bill, 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.

Method	Payment Requests – Contact Information
CALL	**1-855-251-8825** Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services 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.

Method	Payment Requests – Contact Information
WRITE	Anthem Medicare Preferred (PPO) Senior Claims P.O. Box 60007 Los Angeles, CA 90060-0007

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.

Method	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	**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 documents 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.

Method	Medicare – Contact 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 your plan: • **Tell Medicare about your complaint:** You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to **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 and review the information with 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. SHIP is an independent program (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

The SHIP counselors 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 with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

Method to Access SHIP and Other Resources:
• Visit **https://www.shiphelp.org** (Click on SHIP LOCATOR in middle of page) • Select your **STATE** from the list. This will take you to a page with phone numbers and resources specific to your state.

For contact information, please refer to the state-specific agency listing, which is located in the SHIP section of Chapter 11 in this document.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization (QIO) for serving Medicare beneficiaries in each state. QIOs have different names depending on which state they are in.

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

You should contact the QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You made a complaint to your plan and you don't like our response to your complaint.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

For contact information, please refer to the state-specific agency listing located in the QIO section of Chapter 11 in this document.

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 end-stage renal disease 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. 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.

Method	**Social Security – Contact Information**
CALL	**1-800-772-1213** Calls to this number are free. Available 8:00 a.m. to 7:00 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 8:00 a.m. to 7:00 p.m., Monday through Friday.
WEBSITE	**www.ssa.gov**

SECTION 6 Medicaid

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

The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" include:

- **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+).
- **Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

For contact information, please refer to the state-specific agency listing, which is located in the Medicaid section of Chapter 11 in this document.

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Method	Railroad Retirement Board – Contact Information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information, 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	**rrb.gov/**

SECTION 8 Do you have "group insurance" or other health insurance from another group sponsor?

If you have group insurance from another group sponsor, please contact **that group sponsor's benefits administrator** to identify how that coverage will work with these benefits. You may also call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048** with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan for your medical services

SECTION 1 Things to know about getting your medical care as a member of our plan

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

For the details on what medical care is covered by your plan and how much you pay when you get this care, use the benefits chart located at the front of this document and Chapter 4, "Medical benefits (what is covered and what you pay)."

Section 1.1 What are "in-network providers" and "covered services"?

This plan lets you pay the same copay or coinsurance percentage when seeing either in-network providers or out-of-network providers who accept Medicare and our plan as an out-of-network provider. Even if you see an out-of-network provider, you will only pay your copay amount or coinsurance.

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical and health care services. The term "providers" also includes hospitals and other health care facilities.
- **"In-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. In-network providers may also be referred to as "plan providers." With your plan, you are able to see any doctor that accepts Medicare and the plan.
- **"Covered services"** include all the medical care, health care services, supplies and equipment that are covered by your plan. Your covered services for medical care are listed in the benefits chart located at the front of this document.

Section 1.2 Basic rules for getting your medical care covered by our plan

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

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

- **The care you receive is included in your plan's medical benefits chart**. This chart is located at the front of this document.
- **The care you receive is considered medically necessary.** "Medically necessary" means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

- **You 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 an in-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*.

  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 in-network and out-of-network providers to get your medical care

Section 2.1 How to get care from specialists and other in-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.

You do not need to obtain a referral before going to an in-network specialist. See your *Provider Directory* and our website for provider information about in-network specialists.

For certain services, your in-network provider will need to get prior approval from us. This is called getting "prior authorization." Prior authorization is required for in-network providers and recommended for out-of-network providers. Please refer to your benefits chart located at the front of this document for the services for which prior authorization is required or recommended.

You or your provider, including a non-contracted provider, can ask the plan before a service is furnished whether the plan will cover it. You or your provider can request that this determination be in writing. This process is called an advanced determination. If we say we will not cover your services, you, or your provider, 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.

If you do not have an advanced determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside the plan's network for a service; provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

What if a specialist or another in-network provider leaves your 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. If your doctor or specialist leaves 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 notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- 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 to manage your care.
- 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 a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.2 How to get care from out-of-network providers

As a member of your 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. Your 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. 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 pre-visit 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 pre-visit coverage decision, if we later determine that the services are not covered, were not medically necessary, or we could not determine medical necessity due to lack of medical records, 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 (coverage decisions, appeals, complaints)," to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill your local Blue 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.
- Our CMS-defined geographic service area includes all 50 states, Puerto Rico, Washington D.C., Guam, U.S. Virgin Islands, American Samoa and Northern Mariana Islands.

SECTION 3 How to get 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 your loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that 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 provider. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories, and from any provider with an appropriate state license even if they are not part of our network.
- **As soon as possible, notify us of your emergency by calling Member Services.**

What is covered if you have a medical emergency?

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

Your plan may cover emergency care outside of the United States. Please refer to the benefits chart located at the front of this document for additional information.

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 doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by your plan.

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.

Section 3.2 Getting care when you have an urgent need for services

What are "urgently needed services"?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

Your plan may cover urgently needed services outside of the United States and its territories. Please refer to the benefits chart located at the front of this document for additional information.

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 website, **www.anthem.com/ca/calpers**, for information on how to obtain needed care during a disaster.

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost-sharing 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

Your plan covers all medical services that are medically necessary and are obtained consistent with plan rules. These services are listed in the plan's medical benefits chart located at the front of this document. You are responsible for paying the full cost of services that aren't covered by your plan, either because they are not plan-covered services, or plan rules were not followed.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you have used up your benefit for that type of covered service. These costs will not count towards your out-of-pocket maximum.

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. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in 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.

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

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. You are only responsible for the in-network cost sharing for the services in that trial. If you paid more, for example, if you already paid the Original Medicare cost-sharing amount, we will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical research study, you may stay enrolled in your plan and continue to get the rest of your care (the care that is not related to the study) through your plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from your plan. The providers that deliver your care as part of the clinical research study do *not* need to be part of your plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get your plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

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.

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, Original Medicare covers the 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.

After Medicare has paid its share of the cost for these services, your plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of your 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 your plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 5 for more information for submitting requests for payments.

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 your plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation, such as a provider bill, to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, which is the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

When you are part of a clinical research study, neither Medicare nor your 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 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 visiting the Medicare website to read or download the publication "*Medicare and Clinical Research Studies*." (The publication is available at: **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.**) 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 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. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving care from a religious non-medical health care institution

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

- "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 your 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.
- Your plan's coverage of services you receive is limited to *non-religious* 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.

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 a period of 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. Your copayments will end when you obtain ownership of the item.

What happens to payments you made for DME if you switch to Original Medicare?

If you did not acquire ownership of the DME item while in your plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your 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.

SECTION 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage our plan will cover:

- Rental of oxygen equipment (your plan does not allow for purchase of oxygen equipment)
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave your plan and return to Original Medicare?

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

SECTION 8 Information about hospice care

Section 8.1 What is hospice care?

"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Section 8.2 How do you get hospice care if you are terminally ill?

As a member of your plan, you may receive care from any Medicare-certified Hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Member Services to get a list of the Medicare-certified Hospice providers in your area. Phone numbers for Member Services are printed on the back cover of this document. Or you may call the Regional Home Health Intermediary at **1-800-633-4227**. To get more information, visit **www.medicare.gov** on the web. Type "*Medicare Hospice Benefits*" in the search box. Or call **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**.

Section 8.3 How is your hospice care paid for?

If you enroll in a Medicare-certified Hospice program, the Original Medicare Plan, rather than this plan, will pay the hospice provider for the services you receive. Original Medicare will also pay for any services you receive that are not related to your terminal condition.

After Original Medicare has paid its share of the cost for these services, your plan may reimburse part of your costs, if the deductible or coinsurance amount applied by Original Medicare was greater than the amount that would have been applied by this plan.

SECTION 9 Information about organ transplants

Section 9.1 How to get an organ transplant if you need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare and your plan. Some hospitals that perform transplants are approved by Medicare, and others aren't. The Medicare-approved transplant center, in conjunction with your plan, will decide whether you are a candidate for a transplant. When all requirements are met and your plan has authorized the transplant and all associated care, the following types of transplants are covered: heart, lung, combined heart/lung, liver, intestine, combined liver/intestine, kidney, pancreas, combined kidney/pancreas, multivisceral transplant, corneal, stem cell/bone marrow, and donor leukocyte infusion. The following transplants are covered only if they are performed in a Medicare and plan-approved transplant center: heart, lung, combined heart/lung, liver, intestine, combined liver/intestine, kidney, pancreas, and combined kidney/pancreas.

When it is determined that a transplant may be needed, your doctor will need to prior authorize your transplant by calling the Member Services number on the back of your plan membership card and ask to speak with a Transplant Coordinator.

All transplants are required to be prior authorized. Although certain transplants are covered, you must meet specific medical criteria for benefit coverage and the transplant must be performed in an approved facility. The Transplant Coordinator will help you in determining whether the proposed transplant is a covered benefit and that you have met all the requirements. The Transplant Coordinator will also advocate on your behalf with your transplant team to assure your best outcome.

Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If 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 a 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. Your 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. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines.

CHAPTER 4:

Medical benefits (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. The medical benefits chart located at the front of this document lists your covered services and shows how much you will pay for each covered service as a member of your plan. Later in this chapter, you can find information about medical services that are not covered and about 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 explains any applicable yearly deductible for certain categories of service.
- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. If applicable, you pay a copayment at the time you get the medical service. The medical benefits chart located at the front of this document explains more about your copayments.
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. If applicable, you pay a coinsurance at the time you get the medical service. The medical benefits chart located at the front of this document explains more about your coinsurance.

If applicable, the cost of the service, on which your member liability 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.

Your plan provides benefits for all Original Medicare services and may provide additional benefits for services not covered by Original Medicare. For more information on how your member cost share is calculated, please see Chapter 4, Section 1.3.

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.

Section 1.2 What is your plan deductible?

Please refer to the benefits chart located at the front of this document to determine if your plan has an annual deductible.

Until you have paid the deductible amount, you must pay the full cost for most of your covered services. 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 for the rest of the plan 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. Please refer to the benefits chart located at the front of this document to determine which services are not subject to your plan deductible.

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there is a limit on what you have to pay out-of-pocket for covered medical services:

- Your **combined maximum out-of-pocket amount** is located on the benefits chart in the front of this document. This is the most you may pay during the plan 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. If you have paid the amount located on the benefits chart at the front of this document for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the plan year for covered Part A and Part B 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). Please refer to the benefits chart located at the front of this document to determine your plan's maximum out-of-pocket amount, which services are included, and how your plan's maximum out-of-pocket accumulates.

Section 1.4 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.3 above), you may also have a separate maximum out-of-pocket amount that applies only to certain types of medical services. Please refer to the benefits chart located at the front of this document to see if you have separate maximum out-of-pocket amounts and what medical services are included.

Section 1.5 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. Providers may not add additional separate charges called "balance billing." This protection 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 an in-network provider.
- 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 obtain covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, as determined in the contract between the provider and our plan.

- If you obtain 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 obtain covered services from an out-of-network DME supplier who does not participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
- If you obtain services not covered by Medicare but covered by our plan from an out-of-network provider, then you pay the coinsurance amount multiplied by the total charge of the out-of-network provider's bill.

- If you see a provider that has opted out of Medicare, you will be responsible for the entire charge. An opt-out provider is a provider who is not enrolled with Medicare, either as a Medicare participating provider or a non-participating Medicare provider.
- If you believe a provider has "balance billed" you, call Member Services.

SECTION 2 Use the medical benefits chart located at the front of this document, along with this chapter, to find out what is covered and how much you will pay

Section 2.1 Your medical benefits and costs as a member of your plan

The medical benefits chart located at the front of this document lists the services our 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, equipment, and Part B prescription drugs, *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet the 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 in-network provider gets approval in advance from us. This is sometimes called "prior authorization."
  - Covered services that need approval in advance to be covered as in-network services are identified in the medical benefits chart.
  - Prior authorization is only required for services obtained from an in-network provider. You never need prior authorization for out-of-network services from out-of-network providers, but we do request that you notify us of services and recommend you 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 as noted below:
  - If you receive the covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, as determined in the contract between the provider and our 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 Original Medicare payment rate for non-participating providers.
- If you receive covered services from an out-of-network DME supplier who does not participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
- If you receive services not covered by Medicare but covered by our plan from an out-of-network provider, then you pay the coinsurance amount multiplied by the total charge of the out-of-network provider's bill.

- If you see a provider that has opted out of Medicare, you will be responsible for the entire charge. (An opt-out provider is a provider who is not enrolled with Medicare, either as a Medicare participating provider or a non-participating Medicare provider.)
- 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 2024* handbook. View it online at **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.
- If Medicare adds coverage for any new services during 2024, either Medicare or our plan will cover those services.

Some plans may include special supplemental benefits for the chronically ill (SSBCI benefits), as defined by the Centers for Medicare & Medicaid Services (CMS). If you are diagnosed with the following chronic condition(s)* identified below and meet certain criteria, you may be eligible for special supplemental benefits for the chronically ill.

- Chronic alcohol and other drug dependence
- Certain autoimmune disorders
- Cancer (excluding pre-cancer conditions or in-situ status)
- Certain cardiovascular disorders
- Chronic heart failure
- Dementia
- Diabetes mellitus
- End-stage liver disease
- End-stage renal disease (ESRD) requiring dialysis
- Certain hematologic disorders
- HIV/AIDS
- Certain chronic lung disorders

- Certain chronic and disabling mental health conditions
- Certain neurologic disorders
- Stroke
- Other chronic conditions such as those diseases or illnesses that are expected to be present for a majority of the plan year, impact activities of daily living, and require on-going medical treatment

*The above list of chronic conditions was provided by CMS.

For plans that offer SSBCI benefits, you are eligible based on qualifying clinical criteria of a chronic condition as determined and confirmed by your physician.

To determine if your plan offers SSBCI benefits, please refer to the benefits chart located at the front of this document. SSBCI benefits are located under the additional benefits section.

Please contact us to find out exactly which benefits you may be eligible for.

SECTION 3 What services are not covered by your 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.

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 except under the specific conditions listed 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. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Please review the benefits chart at the front of this document to see if any of the below are "included" as part of your plan.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture or acupressure		Available for people with chronic low back pain, unless specified otherwise in the benefits chart at the front of this document
Ambulance service to a physician's office or a physician-directed clinic		Unless specified otherwise in the benefits chart at the front of this document

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Ambulette services		Unless specified otherwise in the benefits chart at the front of this document
Bathroom assistance equipment		Unless specified otherwise in the benefits chart at the front of this document
Benefits to the extent that they are available as benefits through any governmental unit (except Medicaid)		Unless otherwise required by law or regulation The payment of benefits under this *Evidence of Coverage* will be coordinated with such governmental units to the extent required under existing state or federal laws
Charges for completion of claim forms or charges for medical records or reports unless otherwise required by law	Not covered under any condition	
Charges for missed or canceled appointments	Not covered under any condition	
Charges for services incurred after the termination date of this coverage		Except as specified elsewhere in this document
Charges for services incurred prior to your effective date	Not covered under any condition	
Charges in excess of the maximum allowable amount		Unless specified otherwise in the benefits chart at the front of this document
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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		Unless specified otherwise in the benefits chart at the front of this document
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance)		Except when medically necessary and covered under Original Medicare
Experimental medical and surgical procedures, equipment and medications Experimental procedures and items are those items and procedures determined by 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
Eye refractions		Unless specified otherwise in the benefits chart at the front of this document
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition	
For self-help training and other forms of non-medical self-care		Unless specified otherwise in the benefits chart at the front of this document
Full-time nursing care in your home		Unless specified otherwise in the benefits chart at the front of this document
Homemaker services include basic household assistance, including light housekeeping or light meal preparation		Unless specified otherwise in the benefits chart at the front of this document

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Hospice services in a Medicare-participating hospice are not paid for by this PPO, but reimbursed directly by Original Medicare when you are enrolled in a Medicare-certified Hospice		Unless specified otherwise in the benefits chart at the front of this document
Meals delivered to your home		Unless specified otherwise in the benefits chart at the front of this document
Naturopath services (uses natural or alternative treatments)		Unless specified otherwise in the benefits chart at the front of this document
Non-routine dental care		Dental care required to treat illness or injury may be covered as inpatient or outpatient care
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace, Orthopedic or therapeutic shoes for people with diabetic foot disease, unless specified otherwise in the benefits chart at the front of this document
Outpatient prescription drugs, when you have a Medicare Advantage plan that does not cover prescription drugs		Medicare covers a few prescription drugs that you can obtain from a pharmacy under the medical, Part B coverage Please see the benefits chart for more information on drugs covered under your medical benefit
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition	
Private Duty Nurses		Unless specified otherwise in the benefits chart at the front of this document
Private room in a hospital		Covered only when medically necessary
Reversal of sterilization procedures and/or non-prescription contraceptive supplies	Not covered under any condition	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		Only manual manipulation of the spine to correct a subluxation is covered, unless specified otherwise in the benefits chart at the front of this document
Routine dental care, such as cleanings, fillings or dentures		Unless specified otherwise in the benefits chart at the front of this document
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		Only an eye exam and one pair of eyeglasses or contact lenses are covered for people after cataract surgery, unless specified otherwise in the benefits chart at the front of this document
Routine foot care		Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes, unless specified otherwise in the benefits chart at the front of this document
Routine hearing exams, hearing aids, or exams to fit hearing aids		Unless specified otherwise in the benefits chart at the front of this document
Services considered not covered or reasonable and necessary, according to Original Medicare standards		Unless specified otherwise in the benefits chart at the front of this document
Services for court-ordered testing or care		Unless medically necessary and authorized by your plan
Services for illness or injury that occurs as a result of any act of war, declared or undeclared if care is received in a governmental facility	Not covered under any condition	
Services for which you have no legal obligation to pay in the absence of this or like coverage	Not covered under any condition	
Services or supplies primarily for educational, vocational or training purposes		Unless specified otherwise in the benefits chart at the front of this document

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veterans Affairs (VA) facilities		However, when emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference Members are still responsible for our cost sharing amounts
Services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trust or similar person or group	Not covered under any condition	
Services that you get without prior authorization, when prior authorization is required for getting that service	Not covered under any condition	
Surgical treatment for morbid obesity		Except when it is considered medically necessary and covered under Original Medicare
Treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy	Not covered under any condition	

Your plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may find that you have paid more than you expected under the coverage rules of your plan. Or you may receive a bill from a provider. In these cases, you can ask your plan to pay you back. Paying you back is often called "reimbursing" you. It is your right to be paid back by your plan whenever you've paid more than your share of the cost for medical services that are covered by your plan. There may be deadlines that you must meet to get paid back. Please see Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the 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. If we decide not to pay it, we will notify the provider. You should never pay more than plan-allowed cost-sharing. If this provider is contracted, you still have the right to treatment.

Here are examples of situations in which you may need to ask your 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

NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

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. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill the plan for our share of the cost.

- You can receive emergency services from any provider and are only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care. If you accidentally pay the entire amount yourself at the time you receive the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- 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 are 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 an in-network provider sends you a bill you think you should not pay

NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

In-network providers should always bill your 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 covered services. 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.
- Whenever you get a bill from an in-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 an in-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. This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.

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

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 document 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

NOTICE OF CLAIM: In the event that a service is rendered for which you are billed, you have 12 months from the date of service to submit such claims to your plan.

You may request us to pay you back by sending us a request in writing and include your itemized bill, documentation of any payment you have made, and if someone is requesting reimbursement for you, include the Appointment of Representative or Power of Attorney form. It's a good idea to make a copy of your bill and receipts for your records. You must submit your claim to us within 12 months of the date you received the service or item. To make sure you are giving us all the information we need to make a decision, you can fill out our claim form found online at **www.anthem.com/ca/calpers**.

Mail your Medical Claim Form and documents to us at this address:

Anthem Medicare Preferred (PPO)
Senior Claims
P.O. Box 60007
Los Angeles, CA 90060-0007

You must submit your claim to us within one year from the date you received the service or item.

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, we will pay for our share of the cost. Medicare limiting charges may apply, and could be less than the billed amount. 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, please contact your provider to file the claim on your behalf. The claim must be submitted within 12 months from the date of service or according to the contract we have with your provider. We will process covered services according to your plan benefits. Any payment will be made to the provider.**
- 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. We will send you a letter explaining the reasons why we are not sending the payment 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 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. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Your plan must honor your rights and cultural sensitivities as a member of the plan

Section 1.1 We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, or alternate formats)

Your plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how a plan may meet these accessibility requirements include, but are not limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Your plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in alternate formats at no cost if you need it. We are required to give you information about your plan's benefits in a format that is accessible and appropriate for you.

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from your plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services. 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 **1-800-368-1019** or TTY **1-800-537-7697**.

Section 1.2 We must ensure that you get timely access to your covered services

You have the right to choose a provider in your plan's network. 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. Prior authorization may be required on some services. Please refer to the benefits chart for more information.

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 document explains what you can do.

Section 1.3 We must protect the privacy of your personal health information

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

- Your "personal health information" includes the personal information you gave us when you enrolled in your plan, as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you our written notice later in this chapter, called a "Notice of Privacy Practice," that explains these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- Except for the circumstances noted below, if we intend to give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of your 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; typically, this requires that information that uniquely identifies you not be shared.

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 your 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 Member Services.

Below is the Notice of Privacy Practices as of May 2018. This Notice can change so to make sure you're viewing the most recent version, you can request the current version from Member Services. Phone numbers are printed on the back cover of this document, or view it on our website at **www.anthem.com/ca/privacy**.

Protecting your personal health information is important. Every year, we're required to send you specific information about your rights, and some of our duties to help keep your information safe. This notice combines three of these required yearly communications:

- State Notice of Privacy Practices
- Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices
- Breast reconstruction surgery benefits

State Notice of Privacy Practices

When it comes to handling your health information, we follow relevant state laws, which are sometimes stricter than the federal HIPAA privacy law. This notice:

- Explains your rights and our duties under state law.
- Applies to health, dental, vision and life insurance benefits you may have.

Your state may give you additional rights to limit sharing your health information. Please call the Member Services phone number on your plan membership card for more details.

Your personal information

Your non-public (private) personal information (PI) identifies you and it's often gathered in an insurance matter. You have the right to see and correct your PI. We may collect, use and share your PI as described in this notice. Our goal is to protect your PI because your information can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit.

We may receive your PI from others, such as doctors, hospitals or other insurance companies. We may also share your PI with others outside our company – without your approval, in some cases. But we take reasonable measures to protect your information. If an activity requires us to give you a chance to opt out, we'll let you know and we'll let you know how to tell us you don't want your PI used or shared for an activity you can opt out of.

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.

HIPAA Notice of Privacy Practices

We keep the health and financial information of our current and former members private as required by law, accreditation standards and our own internal rules. We're also required by federal law to give you this notice to explain your rights and our legal duties and privacy practices.

Your Protected Health Information

There are times we may collect, use and share your Protected Health Information (PHI) as allowed or required by law, including the HIPAA Privacy rule. Here are some of those times:

Payment: We collect, use and share PHI to take care of your account and benefits, or to pay claims for health care you get through your plan.

Health care operations: We collect, use and share PHI for our health care operations.

Treatment activities: We don't provide treatment, but we collect, use and share information about your treatment to offer services that may help you, including sharing information with others providing you treatment.

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations visit **www.anthem.com/ca/privacy** for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you 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 plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

Sharing your PHI with others: In most cases, if we use or share your PHI outside of treatment, payment, operations or research activities, we have to get your okay in writing first. We must also get your written permission before:

- Using your PHI for certain marketing activities.
- Selling your PHI.
- Sharing any psychotherapy notes from your doctor or therapist.

We may also need your written permission for other situations not mentioned above. You always have the right to cancel any written permission you have given at any time.

You have the right and choice to tell us to:

- Share information with your family, close friends or others involved with your current treatment or payment for your care.
- Share information in an emergency or disaster relief situation.

If you can't tell us your preference, for example in an emergency or if you're unconscious, we may share your PHI if we believe it's in your best interest. We may also share your information when needed to lessen a serious and likely threat to your health or safety.

Other reasons we may use or share your information:

We are allowed, and in some cases required, to share your information in other ways – usually for the good of the public, such as public health and research. We can share your information for these specific purposes:

- Helping with public health and safety issues, such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medicines
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing workers' compensation, law enforcement and other government requests, and to alert proper authorities if we believe you may be a victim of abuse or other crimes.
- Responding to lawsuits and legal actions.

If you're enrolled with us through an employer, we may share your PHI with your group health plan. If the employer pays your premium or part of it, but doesn't pay your health insurance claims, your employer can only have your PHI for permitted reasons and is required by law to protect it.

Authorization: We'll get your written permission before we use or share your PHI for any purpose not stated in this notice. You may cancel your permission at any time, in writing. We will then stop using your PHI for that purpose. But if we've already used or shared your PHI with your permission, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use your genetic information to decide whether we'll give you coverage or decide the price of that coverage.

Race, ethnicity, language, sexual orientation and gender identity: We may receive race, ethnicity, language, sexual orientation and gender identity information about you and protect this information as described in this notice. We may use this information to help you, including identifying your specific needs, developing programs and educational materials and offering interpretation services. We don't use race, ethnicity, language, sexual orientation and gender identity information to decide whether we'll give you coverage, what kind of coverage and the price of that coverage. We don't share this information with unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.

- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for 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 sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see "Your rights" above). If a law requires sharing your information, we don't have to agree to your restriction.
- Call Member Services at the phone number on your plan membership card to use any of these rights. A representative 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.

How we protect information

We're dedicated to protecting your PHI, and we've set up a number of policies and practices to help keep your PHI secure and private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures 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 jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They're not allowed to give your PHI to others without your written permission, unless the law allows it and it's stated in this notice.

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn't cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA.

To see more information

To read more information about how we collect and use your information, your privacy rights, and details about other state and federal privacy laws, please visit our Privacy web page at **www.anthem.com/ca/privacy**.

Calling or texting you

We, including our affiliates and/or vendors, may call or text you by using an automatic telephone dialing system and/or an artificial voice. But we only do this in accordance with the Telephone Consumer Protection Act (TCPA). The calls may be about treatment options or other health-related benefits and services for you. If you don't want to be contacted by phone, just let the caller know or call **1-844-203-3796** to add your phone number to our Do Not Call list. We will then no longer call or text you.

Complaints

If you think we haven't protected your privacy, you can file a complaint with us at the Member Services phone number on your plan membership card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**. We will not take action against you for filing a complaint.

Contact information

You may call us at the Member Services phone number on your plan membership card. Our 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. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. 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're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. This Notice was most recently revised in June 2022. This Notice can change so make sure you're viewing the most recent version. You can request the current version from Member Services at the phone number printed on your plan membership card or view it on our website at **www.anthem.com/ca/privacy**.

FOR MAINE RESIDENTS: Maine Notice of Additional Privacy Rights

The Maine Insurance Information and Privacy Protection Act provides consumers in Maine with the following additional rights.

The right:

- To obtain access to the consumer's recorded personal information in the possession or control of a regulated insurance entity
- To request correction if the consumer believes the information to be inaccurate
- To add a rebuttal statement to the file if there is a dispute
- To know the reasons for an adverse underwriting decision (previous adverse underwriting decisions may not be used as the basis for subsequent underwriting decisions unless the carrier makes an independent evaluation of the underlying facts)

And with very narrow exceptions, the right not to be subjected to pretext interviews.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that 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.

You'll pay your usual deductible, copay and/or coinsurance, as applicable. For details, contact your plan administrator.

For more information about the Women's Health and Cancer Rights Act, go to the United States Department of Labor website at: **www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra**.

Section 1.4 We must give you information about the plan, its network of providers, and your covered services

As a member of your plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Member Services.

- **Information about your plan.** This includes, for example, information about your plan's financial condition.
- **Information about our in-network providers.** 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.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services.
- **Information about why something is not covered and what you can do about it.** Chapter 7 provides information on asking for a written explanation on why a medical service is not covered or if your coverage is restricted. Chapter 7 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 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. 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.** 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. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what 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.** You can get an advance directive 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 who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital 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 appropriate state-specific agency. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document explains what you can do.

Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

Section 1.7 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, sexual orientation, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at **1-800-368-1019**. TTY users should call **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 **Member Services**.
- You can call **SHIP**. For details, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- Or you can **call Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

Section 1.8 How to get more information about your rights

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

- You can call **Member Services**.
- You can call **SHIP**. For details, go to Chapter 2, Section 3. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication *Medicare Rights & Protections*. The publication is available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.**
    - Or you can call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week (TTY **1-877-486-2048**).

SECTION 2 You have some responsibilities as a member of your plan

Things you need to do as a member of your plan are listed below. If you have any questions, please call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *Evidence of Coverage* document to learn what is covered for you and the rules you need to follow to get your covered services.
    - The benefits chart located at the front of this document and Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to your plan, or separate prescription drug coverage, you are required to tell us**. Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in your 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 get the best care, tell your doctors and other health care providers about your health problems. 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 and get an answer you can understand.
- **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:
    - Your group sponsor must pay your plan premiums.
    - You must pay your plan premiums, if any, to your group sponsor (or, if you are billed directly, you must send your payment to the address listed on your billing statement).
    - Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For most of your medical services covered by the plan, you must pay your share of the cost when you get the service, if applicable.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* of our plan service area, you cannot remain a member of our plan**.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please call Member Services. We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of your plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

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

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints**; also called grievances.

Both of these processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the legal terms?

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

- Uses 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" or "coverage 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. Knowing which terms to use will help you communicate more accurately to 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 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to customer service for help. But in some situations you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. 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. For contact information, please refer to the state-specific agency listing located in Chapter 11.

Medicare

You can also contact Medicare to get help. To contact 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 also visit the Medicare website (**www.medicare.gov**).

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

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.

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B prescription drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to Section 9 at the end of this chapter, **How to make a complaint about quality of care, waiting times, member 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

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as medical care. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received a standard denial notice for this medical specialist, or the Evidence of Coverage makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we 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 care before you receive it, you can ask us to make a coverage decision for you. In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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 medical care 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 whether before or after a benefit is received, and you are not satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request an expedited or "fast appeal" of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we were properly following the rules. When we have completed the review, we give you our decision. In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go on to a Level 2 appeal conducted by an independent review organization that is not connected to us.

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Sections 6.4** of this chapter for more information about Level 2 appeals.

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 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call Member Services**.
- **You can get free help from** your State Health Insurance Assistance Program. For contact information, please refer to the state-specific agency listing located in Chapter 11.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)
    - For medical care or Part B prescription drugs, 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.
- **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.
    - If you want a friend, relative, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. The form is also available on Medicare's website at **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.
    - 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.
- **You also have the right to hire a lawyer.** 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 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 you are being discharged 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 *only* to these services: 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 Member Services. You can also get help or information from government organizations such as your State Health Insurance Assistance Program.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

Section 5.1 This section explains 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. These are the benefits described in the benefits chart located at the front of this document and in Chapter 4 of this document, "*Medical benefits (what is covered and what you pay)*." In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section explains 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. **Ask for a coverage decision. Section 5.2**.
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. **Ask for a coverage decision. Section 5.2**.
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an appeal. Section 5.3**.
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask your plan to reimburse you for this care. **Send us the bill. Section 5.5**.
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. **Make an appeal. Section 5.3**.
    - **NOTE:** If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

LEGAL TERMS	When a coverage decision involves your medical care, it is called an **"organization determination."** A "fast coverage decision" is called an **"expedited determination."**

Step 1: Decide if you need a "standard coverage decision" or a "fast coverage decision."

A "standard coverage decision" is usually made within 14 days or 72 hours for Part B drugs. A "fast coverage decision" is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. In order to get a fast coverage decision, you must meet two requirements:

- You may only ask for coverage for medical care items and/or services (not requests for payment for items and/or services 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 do not approve a fast coverage decision, we will send you a letter that:
    - Explains that we will use the standard deadlines.
    - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
    - Explains that you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

Step 2: Ask our plan to make a coverage decision or fast coverage decision

- Start by calling, writing or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we will give you an answer within 14 calendar days after we receive your request **for a medical item or service**. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive your request.

- **However**, if you ask for more time, or if we need information that may benefit you **we can take up to 14 more days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should not take extra days, you can file a "fast complaint." We will give you an answer to your complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. See Section 9 of this chapter for information about complaints.)

For fast coverage decisions we use an expedited timeframe

A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.

- However, if you ask for more time, or if we need more information that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint". (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **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 4: If we say no to your request for coverage for medical care, you can appeal.

- If your plan says no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you are going on to Level 1 of the appeals process.

Section 5.3 Step-by-step: How to make a Level 1 appeal

LEGAL TERMS	An appeal to the plan about a medical care coverage decision is called a plan **"reconsideration."** A "fast appeal" is also called an **"expedited reconsideration."**

Step 1: Decide if you need a "standard appeal" or a "fast appeal."

A "standard appeal" is usually made within 30 days or 7 days for Part B drugs. A "fast appeal" is generally made within 72 hours.

- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 5.2 of this chapter.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal** in writing to the fax number or address provided in Chapter 2, Section 1, under "Appeals for Medical Care – Contact Information." You may also ask for an expedited appeal by calling us at the phone number shown in Chapter 2, Section 1.
- **If you are asking for a fast appeal, make your appeal in writing or call us**. Chapter 2 has contact information.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us, or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal**.

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information needed, possibly contacting you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals 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.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - 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 review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - If you believe we should *not* take extra days, you can file a "fast complaint." 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 (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or within **7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for Level 2.

Section 5.4 Step-by-step: How a Level 2 appeal is done

LEGAL TERMS	The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and it is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We 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**.
- 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

- For the "fast appeal" the review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- For the "standard appeal" if your request is for a medical item or service, the review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, it can take up to **14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests**. For expedited requests we have **24 hours** from the date we receive 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 your plan 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." In this case, the independent review organization will send you a letter:
    - Explaining its decision.

- Notifying you of the right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
- Telling you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains Levels 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you have received from a provider. It also explains 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 asking for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** 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 medical care 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.

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. For appeals concerning reimbursement, please note:

- 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, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you 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 you are being discharged 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.

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 is decided, your doctor or the hospital staff will tell you.
- 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.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that explains your rights

Within two days of being admitted to the hospital, 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. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse) ask any hospital employee for it. If you need help, please call Member Services or **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. (TTY **1-877-486-2048**).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
    - 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.
    - Where to report any concerns you have about quality of your hospital care.
    - Your right to request an immediate review of the decision to discharge you if you think you are being discharged from the hospital too soon. This 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.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
    - You or someone who is acting on your behalf will be asked to sign the notice.
    - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.
3. **Keep your copy of the notice** handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
    - If you sign the notice more than two days before your discharge date, 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 Member Services. 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**. You can also see the notice online at **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

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 your plan 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**.
- **Meet the deadlines**.
- **Ask for help if you need it**.

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

The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the Federal government to check on and help improve the quality of care for people with Medicare. These experts are not part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an "immediate" review. You must act quickly.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) explains how to reach this organization. (Or find the name, address and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 11.)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and **no later than midnight the day of your discharge**.
    - If you meet this deadline, you may 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, and you still wish to appeal, you must make an appeal directly to your plan instead. For details about this other way to make your appeal, see Section 6.4.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted we will give you a Detailed Notice of Discharge. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

- You can get a sample of the *Detailed Notice of Discharge* by calling Member Services 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 **www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices**.

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

- Health professionals at the Quality Improvement Organization ("the reviewers") will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you 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 told us of your appeal, you will get a written notice from us that gives your planned discharge date. This notice explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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

What happens if the answer is yes?

- If the review organization says *yes*, **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.

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **your plan's 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 said *no* to 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

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at their decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said *no* to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date 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 Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes

- **Your plan 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.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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 you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains 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 to change your hospital discharge date?

LEGAL TERMS	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement 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

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

- **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. Chapter 2 has contact information.

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 see if the decision about when you should leave the hospital was fair and followed all the rules.

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

- **If we say yes to your appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are 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 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 appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 *Alternate* appeal process

LEGAL TERMS	The formal name for the "independent review organization" is the **"Independent Review Entity."** It is sometimes called the **"IRE."**

The **independent review organization is an independent organization hired by Medicare**. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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. Section 9 of this chapter explains 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.

- 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 your plan must pay you back for our share of the costs of hospital care you 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 that your planned hospital discharge date was medically appropriate.
    - The written notice you get from the independent review organization will tell how to start a Level 3 appeal review process, which is handled by an Administrative Law Judge or attorney adjudicator.

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 a Level 3 appeal.
- Section 8 in this chapter explains 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 *only* about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered home health care services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility), 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.

When your plan decides 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 explains 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 your plan is going to stop covering your care. The notice tells you:
    - The date when your plan will stop covering the care for you.

- How to request a "fast track appeal" to request us to keep covering your care for a longer period of time.

LEGAL TERMS	**"Notice of Medicare Non-Coverage."** It tells you 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 explains how you can request a fast-track appeal.)

2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you received it.**
    - 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's decision to stop 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.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts who are paid by the Federal government to check on and improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you received (*Notice of Medicare Non-Coverage*) explains how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the state-specific agency listing located in Chapter 11.)

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an 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.

LEGAL TERMS	**"Detailed Explanation of Non-Coverage."** Notice that provides details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization, called "the reviewers," will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that your plan has given to them.
- By the end of the day the reviewers tell your plan of your appeal, you will get the **Detailed Explanation of Non-Coverage** from the plan that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **your plan 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. There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we have told you**.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, 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.

- If reviewers say *no* to your Level 1 appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make a Level 2 appeal.

Section 7.4 Step-by-step: How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

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

- You must ask for this review **within 60 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?

- **Your plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Your plan 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 they made to your Level 1 appeal.
- 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 an Administrative Law Judge or attorney adjudicator.

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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 is handled by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains 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 your plan instead

As explained above, 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

LEGAL TERMS	A "fast review" (or "fast appeal") is also called an **"expedited appeal."**

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

- **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. Chapter 2 has contact information.

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 your plan's coverage for services you were receiving.

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

- **If we say yes to your 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 appeal**, then your coverage will end on the date we told you and your plan 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.

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

LEGAL TERMS	The formal name for the **"independent review organization"** is the "Independent Review Entity." It is sometimes called the **"IRE."**

Step-by-Step: Level 2 *Alternate* appeal Process

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your "fast appeal." This organization decides whether the decision should be changed. **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.

Step 1: We 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. Section 9 of this chapter explains 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.

- 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 your plan must 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 your 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 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 you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- At Level 3, your appeal is reviewed by an Administrative Law Judge or attorney adjudicator. Section 8 in this chapter explains more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Appeal Levels 3, 4, and 5 for Medical Service Requests

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. The written response you receive to your Level 2 appeal will explain how to make 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 — **Administrative Law Judge or an attorney adjudicator who works for the Federal government will review your appeal and give you an answer.**

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator'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 medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept 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. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may* or *may not* be over.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We will decide whether to appeal this decision to Level 5.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after receiving the 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 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 may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal A judge at the Federal District Court will review your appeal.

- A judge will review all of the information and decide yes or no to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, member service, or other concerns

Section 9.1 What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems related to quality of care, waiting times, and the member service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?

Complaint	Example
Disrespect, poor member service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • 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 Member Services 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	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a "fast coverage decision" or a "fast appeal," and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

LEGAL TERMS

- A "**Complaint**" is also called a "**grievance**."
- "**Making a complaint**" is also called "**filing a grievance**."
- "**Using the process for complaints**" is also called "**using the process for filing a grievance**."
- A "**fast complaint**" is also called an "**expedited grievance**."

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step**. If there is anything else you need to do, Member Services will let you know.
- **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. Other persons may already be authorized by the court or in accordance with state law 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 Member Services.
    - 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.
- The deadline for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we 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.
- **Most complaints are answered within 30 calendar days**. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **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**.
- **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 include our reasons in our response to you.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization**.

- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. Chapter 2 has contact information.

Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about your plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**. You may also call **1-800-MEDICARE (1-800-633-4227)**. TTY users can call **1-877-486-2048**.

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to 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. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 explains situations when we must end your membership.

If you are leaving our plan, our plan must continue to provide your medical care and you will continue to pay your cost share until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan anytime during the year.

Section 2.1 You can end your membership during the Annual Enrollment Period for Individual (non-group) plans

You can end your membership in our plan during the **Annual Enrollment Period for Individual (non-group) plans**, also known as the "Annual Open Enrollment Period." During this time, review your health and drug coverage and decide on coverage for the upcoming year.

- **The Annual Enrollment Period for Individual (non-group) plans** is from October 15 through December 7.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
    - Another Individual (non-group) Medicare health plan, with or without prescription drug coverage.
    - Original Medicare *with* a separate Individual (non-group) Medicare prescription drug plan.

      OR
    - Original Medicare without a separate Individual (non-group) Medicare prescription drug plan.
- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor.**
- **Your membership will end in our plan** when your new plan's coverage begins.

Section 2.2 You may be able to end your membership during the Medicare Advantage Open Enrollment Period for Individual (non-group) Plans

You have the opportunity to make *one* change to your health coverage during the **Individual (non-group) Medicare Advantage Open Enrollment Period**.

- **The annual Individual (non-group) Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Individual (non-group) Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
    - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor.**
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare 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

Group-sponsored plans may allow changes to their retirees' enrollment. This typically occurs during the group's open enrollment period. This may be any time of the year and does not have to coincide with the individual open enrollment period from October 15 to December 7.

Please check with your group sponsor for additional enrollment and disenrollment options, and the impact of any changes to your group-sponsored retiree benefits.

In certain situations, Medicare Advantage members may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples; for the full list, you can contact your plan, call Medicare, or visit the **Medicare website (www.medicare.gov**):
    - Usually, when you have moved outside of your plan's service area.
    - If you have Medicaid.
    - If we violate our contract with you.
    - If you get care in an institution, such as a nursing home or long-term care (LTC) hospital.
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services.

- **The enrollment time periods vary** depending on your situation.
- **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. You can choose:
    - An Individual (non-group) Medicare health plan. You can choose a plan with or without prescription drug coverage.
    - Original Medicare *with* a separate Individual (non-group) Medicare prescription drug plan.

      OR
    - Original Medicare *without* a separate Medicare prescription drug plan.
- **Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in your plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor.**
- **Your membership will end** on the first of the month after we receive your request to change plans or the date you request we terminate coverage on this plan, whichever is later.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- Contact your group sponsor to get information on options available to you.
- Call **Member Services**.
- Find the information in the ***Medicare & You 2024*** handbook.
- Contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY **1-877-486-2048**).

SECTION 3 How do you end your membership in our plan?

Ending your group-sponsored Medicare Advantage plan may impact your eligibility for other coverage sponsored by your group or mean that you will not be able to re-enroll in the plan in the future. Before ending your group-sponsored Medicare Advantage coverage, please contact your group sponsor.

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:
An Individual (non-group) Medicare health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. • You will automatically be disenrolled from your group-sponsored plan when your new plan's coverage begins.
Original Medicare with a separate Individual (non-group) Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan between October 15 and December 7. • You will automatically be disenrolled from your group-sponsored 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 Member Services if you need more information on how to do this. • 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 your group-sponsored plan when your coverage in Original Medicare begins.

Note: If you also have creditable prescription drug coverage (e.g., standalone PDP) and disenroll from that coverage, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later after going without creditable prescription drug coverage for 63 days or more in a row.

SECTION 4 Until your membership ends, you must keep getting your medical items, services through our plan

Until your membership ends, and your new Medicare coverage begins, you must continue to get your medical items, services through our plan.

- **Continue to use our network providers to receive medical care.**
- **If you are hospitalized on the day that your membership ends, your hospital stay will be covered by your plan until you are discharged**, even if you are discharged after your new health coverage begins.

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We 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.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in your plan's area.
- If you become incarcerated (go to prison).
- If you are no longer 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 plan 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 your group notifies us that they are canceling the group contract for this plan.
- If the premiums paid by your group sponsor for this plan are not paid in a timely manner.
- If you pay your plan premium directly to us, and you do not pay your plan premiums for 90 days.
    - We must notify you in writing that you have 90 days to pay your plan premium before we end your membership.
- If your group sponsor informs this plan of your loss of eligibility for their group coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership, call Member Services.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

We are not allowed to ask you to leave our plan for any health-related reason.

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 **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.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

The principal law that applies to this *Evidence of Coverage* document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in. This may affect your rights and responsibilities even if the laws are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like your plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

If you want more information or have concerns about discrimination or unfair treatment, 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. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **https://www.hhs.gov/ocr/index.html**.

If you have a disability and need help with access to care, please call us. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

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, your plan, 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 Notice about subrogation and reimbursement

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 CFR 411.37, and pursuant to 42 CFR 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 your plan.

SECTION 5 Additional legal notices

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, as applicable, 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 12 months from the date of service to submit such claim(s) to your plan.

You may submit such claims to:

Anthem Medicare Preferred (PPO)
Senior Claims
P.O. Box 60007
Los Angeles, CA 90060-0007

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 your plan, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart located at the front of this document.

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.

Termination of operation

In the event of the termination 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, your plan 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, your plan would arrange for you to obtain, without a 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 provider. 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 provider 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 an out-of-network provider instead of an in-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

Your plan may, at its sole discretion, cover services and supplies not specifically covered by the *Evidence of Coverage*.

This applies if your 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 Member Services. Your 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 a "living will" and a "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 11 of this document explains 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's Department of Health.

Continuity and coordination of care

Your plan 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, your plan 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.

InterPlan/Medicare Advantage Program

- **Member Liability Calculation**

  When you receive covered healthcare services outside of our service area from a Medicare Advantage PPO network provider, the cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

  - The Medicare allowable amount for covered services; or
  - The amount the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.

- **Non-participating Health Care Providers Outside Our Service Area**

  When covered healthcare services are provided outside of our service area by non-participating healthcare providers, the amount(s) you pay for such services will be based on either Medicare's limiting charge where applicable or the provider's billed charge. Payments for out-of-network emergency services will be governed by applicable federal and state law.

In these above instances the service area refers to the geographic area that we are licensed to sell the Blue brand.

CHAPTER 10:

Definitions of important words

Allowed Amount – The allowed amount is either:

1. The rate negotiated with in-network providers;
2. The Medicare-allowable amount for out-of-network providers who accept Medicare assignment;
3. The limiting charge for providers who do not accept assignment but who are subject to the limiting amount;
4. The provider's actual charge when the provider does not accept assignment and is not subject to the limiting amount; or
5. The provider's actual charge for non-Medicare covered benefits, your plan covers, when the provider is an out-of-network provider.

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 – The time period of October 15 until December 7 of each year when members can change their health or drug plans or switch to Original Medicare.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

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 our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not 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.

Calendar Year – The period beginning January 1 of any year through December 31 of the same year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Chronic-Care Special Needs Plan – C-SNPs are SNPs that restrict enrollment to MA eligible individuals who have one or more severe or disabling chronic conditions, as defined under 42 CFR 422.2, including restricting enrollment based on the multiple commonly co-morbid and clinically-linked condition groupings specified in 42 CFR 422.4(a)(1)(iv).

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the amount you will pay in a year for all Part A and Part B services from both in-network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, we may also have a maximum out-of-pocket amount for certain types of services. See Chapter 4, Section 1.3 for information about your combined

maximum out-of-pocket amount. Please refer to the benefits chart at the front of this document for information about your combined maximum out-of-pocket amount and to see if you have separate maximum out-of-pocket amounts for specific medical services.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used *only* for certain types of problems. This includes problems related to quality of care, waiting times, and the member service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – If applicable, 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, or hospital outpatient visit. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – If applicable, cost sharing refers to amounts that a member may have to pay when services are received. It 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 term we use in this *EOC* to mean all of the health care services and supplies that are covered by our plan.

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 provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – If applicable, the amount you must pay for health care before our plan pays.

Diagnostic Testing – Testing performed to detect disease when clinical indications of active disease are present.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dual Eligible Special Needs Plans (D-SNP) – D-SNPs enroll individuals who are entitled to both Medicare (title XVIII of the Social Security Act) and medical assistance from a state plan under Medicaid (title XIX). States cover some Medicare costs, depending on the state and the individual's eligibility.

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 (and, if you are a pregnant

woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate or stabilize an emergency medical condition.

***Evidence of Coverage* (*EOC*) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of your plan.

Grievance – A type of complaint you make about our plan or providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less to live. 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.

Hospital Inpatient Stay – A hospital stay is 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" under observation. Be sure to ask the hospital if you are an inpatient status or outpatient observation status when staying overnight as the plan benefits are different for each category.

Hospital Observation Stay – Hospital outpatient services given to help the doctor decide if you need to be admitted as an inpatient or can be discharged. Observation services may be given in the Emergency Department (ED) or another area of the hospital and may include an overnight stay up to 48 hours.

In-Network Maximum Out-of-Pocket Amount – Some plans have separate in-network and out-of-network maximum out-of-pocket amounts. In this case, in-network maximum out-of-pocket is the most you will pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from in-network providers for the rest of the contract year. However, until you reach your combined out-of-pocket maximum amount, which includes services received from an out-of-network provider, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for covered medical services, you may also have a maximum out-of-pocket amount for certain types of services.

In-Network Provider – "Provider" is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. "**In-network providers**" have an agreement with your plan to accept our contracted rate as payment in full, and in some cases, to coordinate as well as provide covered services to members of your plan. In-network providers are also called "plan providers" or "network providers."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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. 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.

Institutional Equivalent Special Needs Plan (SNP) – A plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the state assessment. The assessment must be performed using the same respective state level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Institutional Special Needs Plan (SNP) – A plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These facilities may include a skilled nursing facility (SNF), nursing facility (NF), (SNF/NF), an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), and/or an inpatient psychiatric facility, and/or facilities approved by CMS that furnishes similar long-term, health care services that are covered under Medicare Part A, Medicare Part B, or Medicaid; and whose residents have similar needs and health care status to the other named facility types. An institutional Special Needs Plan must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the plan year for covered Part A and Part B services. Amounts you pay for your plan, Medicare Part A and Part B premiums, do not count toward the maximum out-of-pocket amount. See the benefits chart at the front of this document for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Necessary – Services, supplies or drugs that are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (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 i) HMO, ii) PPO, iii) a Private Fee-for-Service (PFFS) plan, or a iv) Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a

Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

Medicare Advantage Open Enrollment Period (non-group plans) – The time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after an individual is first eligible for Medicare.

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, must cover all of the services that are covered by Medicare Part A and Part B. The term Medicare-Covered Services does not include the extra benefits, such as vision, dental or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

"**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).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances and appeals.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this document.

Original 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 that does not have a contract with our plan to coordinate or provide covered services to members of your plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

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.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. If you would like to know if PACE is available in your state, please contact Member Services.

Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Plan 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 "plan providers" when they have an agreement with this plan to accept our contracted rate as payment in full, and in some cases to coordinate as well as provide covered services to members of this plan. This plan pays plan providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services.

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 in-network or out-of-network providers. On some PPO plans, 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 in-network (preferred) providers and some plans may have a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy.

Prior Authorization – Approval in advance to get services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other in-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 benefits chart located at the front of this document.

Prosthetics and Orthotics – Medical devices including, 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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Screening Exam – A routine exam to detect evidence of unsuspected disease.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you must use, it's also generally the area where you can get routine (non-emergency) 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 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 plan 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 – Covered services that are not emergency services, provided when the in-network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

CHAPTER 11:

State organization contact information

SECTION 1 State Health Insurance Assistance Program (SHIP)

The following state agency information was updated on 06/01/2023. For more recent information or other questions, please contact Member Services.

Alabama

Alabama's State Health Insurance Asst. Program
201 Monroe Street, Suite 350
Montgomery, AL 36104
1-800-243-5463, TTY: **711**
http://www.alabamaageline.gov/ship/

Alaska

Alaska State Health Insurance Asst. Program
1835 Bragaw Street, Suite 350
Anchorage, AK 99508
1-800-478-6065, TTY: **1-800-770-8973**
8:00 a.m. to 5:00 p.m.
http://dhss.alaska.gov/dsds/Pages/medicare/default.aspx

Arizona

AZ State Health Insurance Asst. Program
1789 W. Jefferson Street, #950a
Phoenix, AZ 85007
1-800-432-4040, TTY: **711**
https://des.az.gov/services/older-adults/medicare-assistance

Arkansas

AR Senior Health Insurance Information Program
1 Commerce Way
Little Rock, AR 72202
1-800-282-9134, TTY: **711**
https://insurance.arkansas.gov/pages/consumer-services/senior-health/

California

CA Health Insurance Counseling & Advocacy Program
2880 Gateway Oaks Drive, Suite 200
Sacramento, CA 95833
1-916-419-7500, TTY: **1-800-735-2929**
8:00 a.m. to 5:00 p.m.
https://www.aging.ca.gov/hicap/

Colorado

Colorado Senior Health Care & Medicare Asst.
1560 Broadway, Suite 850
Denver, CO 80202
1-888-696-7213, TTY: **1-303-894-7880**
https://doi.colorado.gov/insurance-products/health-insurance/senior-health-care-medicare

Connecticut

CHOICES (CT program for Health insurance Asst.)
55 Farmington Ave., 12 Floor
Hartford, CT 06105-3730
1-800-994-9422, TTY: **1-860-247-0775**
https://portal.ct.gov/AgingandDisability/Content-Pages/Programs/CHOICES-Connecticuts-program-for-Health-insurance-assistance-Outreach-Information-and-referral-Couns

Delaware

Delaware Medicare Asst. Bureau (DMAB)
841 Silver Lake Boulevard
Dover, DE 19904
1-800-336-9500, TTY: **711**
https://insurance.delaware.gov/divisions/dmab/

District of Columbia

DC State Health Insurance Asst. Program
500 K Street, NE
Washington, DC 20002
1-202-727-8370, TTY: **711**
https://dacl.dc.gov/service/health-insurance-counseling

Florida

Florida SHINE
4040 Esplanade Way, Suite 270
Tallahassee, FL 32399-7000
1-800-963-5337, TTY: **1-800-955-8770**
http://www.floridashine.org

Georgia

Georgia State Health Insurance Asst. Program
2 Peachtree Street NW, 22nd Floor
Atlanta, GA 30303
1-866-552-4464, TTY: **711**
https://aging.georgia.gov/georgia-ship

Hawaii

Hawaii State Health Insurance Asst. Program
250 S. Hotel Street, Suite 406
Honolulu, HI 96813-2831
1-888-875-9229, TTY: **1-866-810-4379**
https://www.hawaiiship.org/services/

Idaho

Idaho Senior Health Insurance Benefits Advisors
700 West State Street, 3rd Floor
P.O. Box 83720
Boise, ID 83720-0043
1-800-247-4422, TTY: **711**
https://doi.idaho.gov/shiba/

Illinois

Illinois Senior Health Insurance Program
One Natural Resources Way, #100
Springfield, IL 62702-1271
1-800-252-8966, TTY: **1-888-206-1327**
https://ilaging.illinois.gov/ship.html

Indiana

Indiana State Health Insurance Asst. Program
311 W. Washington Street, Suite 300
Indianapolis, IN 46204-2787
1-800-452-4800, TTY: **1-866-846-0139**
https://www.in.gov/ship/

Iowa

Iowa Senior Health Insurance Information Program
1963 Bell Avenue, Suite 100
Des Moines, IA 50315
1-800-351-4664, TTY: **1-800-735-2942**
https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas
503 S. Kansas Ave., New England Bldg
Topeka, KS 66603-3404
1-800-860-5260, TTY: **711**
http://www.kdads.ks.gov/commissions/commission-on-aging/medicare-programs/shick

Kentucky

Kentucky State Health Insurance Asst. Program
275 E. Main Street, 3E-E
Frankfort, KY 40621
1-877-293-7447, TTY: **711**
https://chfs.ky.gov/agencies/dail/Pages/ship.aspx

Louisiana

LA Senior Health Insurance Information Program
P.O. Box 94214
Baton Rouge, LA 70804
1-800-259-5300, TTY: **711**
http://www.ldi.la.gov/SHIIP

Maine

Maine State Health Insurance Asst. Program
109 Capitol Street
Augusta, ME 04333
1-877-353-3771, TTY: **711**
http://www.maine.gov/dhhs/oads/community-support/ship.html

Maryland

Maryland State Health Insurance Asst. Program
301 W. Preston Street, Suite 1007
Baltimore, MD 21201
1-800-243-3425, TTY: **711**
https://aging.maryland.gov/Pages/state-health-insurance-program.aspx

Massachusetts

The Massachusetts SHINE Program
1 Ashburton Place, 11th Floor
Boston, MA 02108
1-800-243-4636, TTY: **1-800-439-2370**
http://www.mass.gov/elders/healthcare/shine/serving-the-health-information-needs-of-elders.html

Michigan

MMAP (Michigan Medicare/Medicaid Asst. Program)
6105 W. St. Joseph, Suite 204
Lansing, MI 48917
1-800-803-7174, TTY: **711**
http://www.mmapinc.org

Minnesota

MN State Health Insurance Asst. Program
540 Cedar Street
St. Paul, MN 55164-0976
1-800-333-2433, TTY: **1-800-627-3529**
https://mn.gov/senior-linkage-line/

Mississippi

Mississippi State Health Insurance Asst. Program
200 South Lamar Street
Jackson, MS 39201
1-601-359-4500, TTY: **711**
http://www.mdhs.ms.gov/adults-seniors/services-for-seniors/state-health-insurance-assistance-program/

Missouri

MO CLAIM State Health Insurance Asst. Program
1105 Lakeview Avenue
Columbia, MO 65201
1-800-390-3330, TTY: **711**
http://www.missouriclaim.org

Montana

Montana State Health Insurance Asst. Program
1100 N Last Chance Gulch, 4th Floor
Helena, MT 59601
1-800-551-3191, TTY: **711**
http://dphhs.mt.gov/SLTC/aging/SHIP

Nebraska

Nebraska SHIP
2717 S. 8th Street, Suite 4
Lincoln, NE 68508
1-800-234-7119, TTY: **1-800-471-4610**
http://www.doi.ne.gov/shiip

Nevada

Nevada State Health Insurance Asst. Program
3416 Goni Road, Suite D-132
Carson City, NV 89706
1-800-307-4444, TTY: **711**
https://adsd.nv.gov/Programs/Seniors/SHIP/SHIP_Prog/

New Hampshire

NH State Health Insurance Asst. Program
129 Pleasant Street, Gallen State Office Park
Concord, NH 03301
1-866-634-9412, TTY: **1-800-735-2964**
https://www.servicelink.nh.gov/medicare/index.htm

New Jersey

New Jersey State Health Insurance Asst. Program
P.O. Box 715
Trenton, NJ 08625-0715
1-800-792-8820, TTY: **711**
http://www.state.nj.us/humanservices/doas/services/ship/

New Mexico

New Mexico State Health Insurance Asst. Program
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080, TTY: **1-505-476-4937**
https://aging.nm.gov/services/aging-disability-resource-center-adrc/medicare

New York

New York Health Insurance Asst. Program
2 Empire State Plaza, 5th Floor
Albany, NY 12223-1251
1-800-701-0501, TTY: **711**
https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

North Carolina

NC Medicare Health Insurance Information Program
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212, TTY: **711**
http://www.ncdoi.com/SHIIP/

North Dakota

ND Senior Health Insurance Counseling (SHIC)
600 East Boulevard Ave., 5th Floor
Bismarck, ND 58505-0320
1-888-575-6611, TTY: **1-800-366-6888**
http://www.nd.gov/ndins/shic/

Ohio

Ohio Senior Health Insurance Information Program
50 West Town Street, 3rd Floor - Suite 300
Columbus, OH 43215
1-800-686-1578, TTY: **1-614-644-3745**
https://insurance.ohio.gov/about-us/divisions/oshiip

Oklahoma

OK Senior Health Insurance Counseling Program
400 NE 50th Street
Oklahoma City, OK 73105
1-800-763-2828, TTY: **711**
https://www.oid.ok.gov/consumers/information-for-seniors/senior-health-insurance-counseling-program-ship/

Oregon

OR Senior Health Insurance Benefits Asst. Program
350 Winter Street NE
Salem, OR 97309-0405
1-800-722-4134, TTY: **711**
https://shiba.oregon.gov/Pages/index.aspx

Pennsylvania

PA Medicare Education & Decision Insight (PA MEDI)
555 Walnut Street, 5TH Floor
Harrisburg, PA 17101-1919
1-800-783-7067, TTY: **711**
https://www.aging.pa.gov/aging-services/medicare-counseling/Pages/default.aspx

Rhode Island

Rhode Island State Health Insurance Asst. Program
25 Howard Ave., Building 57
Cranston, RI 02920
1-888-884-8721, TTY: **1-401-462-0740**
https://oha.ri.gov/Medicare

South Carolina

South Carolina Insurance Counseling Assistance
1301 Gervais Street, Suite 350
Columbia, SC 29201
1-800-868-9095, TTY: **711**
https://www.getcaresc.com/guide/insurance-counseling-medicaremedicaid

South Dakota

SD Senior Health Information & Insurance Education
700 Governors Drive
Pierre, SD 57501
1-605-773-3165, TTY: **711**
http://www.shiine.net

Tennessee

TN State Health Insurance Asst. Program (TN SHIP)
500 Deaderick Street, Suite 825
Nashville, TN 37243-0860
1-877-801-0044, TTY: **711**
https://www.tn.gov/aging/our-programs/state-health-insurance-assistance-program--ship-.html

Texas

TX Health Information Counseling Advocacy Program
701 W. 51st Street
Austin, TX 78751
1-800-252-9240, TTY: **711**
https://www.hhs.texas.gov/services/health/medicare

Utah

Utah Senior Health Insurance Information Program
195 North 1950 West
Salt Lake City, UT 84116
1-877-424-4640, TTY: **711**
https://daas.utah.gov/seniors/

Vermont

Vermont State Health Insurance Program
280 State Drive HC2 South
Waterbury, VT 05671-2070
1-802-241-0294, TTY: **711**
https://asd.vermont.gov/services/ship

Virginia

VA Insurance Counseling and Asst. Program (VICAP)
1610 Forest Avenue, Suite 100
Henrico, VA 23229
1-800-552-3402, TTY: **711**
https://www.vda.virginia.gov/vicap.htm

Washington

WA Statewide Health Insurance Benefits Advisors
P.O. Box 40255
Olympia, WA 98504-0255
1-800-562-6900, TTY: **1-360-586-0241**
https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba

West Virginia

WV State Health Insurance Asst. Program (WV SHIP)
1900 Kanawha Blvd. E.
Charleston, WV 25305
1-877-987-4463, TTY: **711**
http://www.wvship.org

Wisconsin

SHIP: Medicare Counseling for Wisconsin Residents
1 West Wilson Street
Madison, WI 53703
1-608-266-1865, TTY: **711**
https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

WY Health Insurance Information Program (WSHIIP)
106 W. Adams
Riverton, WY 82501
1-800-856-4398, TTY: **711**
https://www.wyomingseniors.com/services/wyoming-state-health-insurance-information-program

SECTION 2 Quality Improvement Organization (QIO)

The following state agency information was updated on 06/01/2023. For more recent information or other questions, please contact Member Services.

Alabama

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Alaska

KEPRO Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Arizona

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Arkansas

KEPRO - Region 6
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

California

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Colorado

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Connecticut

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Delaware

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

District of Columbia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Florida

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Georgia

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Hawaii

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Idaho

KEPRO - Region 10
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Illinois

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Indiana

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Iowa

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kansas

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Kentucky

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Louisiana

KEPRO - Region 6
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maine

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Maryland

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Massachusetts

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Michigan

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Minnesota

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Mississippi

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Missouri

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Montana

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Nebraska

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Nevada

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Hampshire

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New Jersey

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

New Mexico

KEPRO - Region 6
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

New York

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

North Carolina

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

North Dakota

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Ohio

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Oklahoma

KEPRO - Region 6
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Oregon

KEPRO - Region 10
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Pennsylvania

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Rhode Island

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Carolina

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

South Dakota

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Tennessee

KEPRO - Region 4
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Texas

KEPRO - Region 6
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Utah

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Vermont

KEPRO - Region 1
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Washington

KEPRO - Region 10
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

West Virginia

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wisconsin

Livanta LLC BFCC-QIO Program
10820 Guilford Rd, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
Monday through Friday: 9:00 a.m. - 5:00 p.m. (Local Time)
https://www.livantaqio.com/en

Wyoming

KEPRO - Region 8
5201 West Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
Monday through Friday: 9:00 a.m. - 5:00 p.m. and 11:00 a.m. to 3:00 p.m. on Saturday, Sunday and holidays in all local time zones
http://www.keproqio.com/default.aspx

SECTION 3 State Medicaid Offices

The following state agency information was updated on 06/01/2023. For more recent information or other questions, please contact Member Services.

Alabama

Alabama Medicaid
P.O. Box 5624
Montgomery, AL 36103-5624
1-334-242-5000, TTY: **1-800-253-0799**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.medicaid.alabama.gov

Alaska

DenaliCare
P.O. Box 110642
Juneau, AK 99811-0642
1-800-478-7778, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://health.alaska.gov/dpa/Pages/medicaid/default.aspx

Arizona

Arizona Health Care Cost Containment System
801 E. Jefferson
Phoenix, AZ 85034
1-800-523-0231, TTY: **1-800-842-6520**
8:00 a.m. - 1:00 p.m. and 2:00 p.m. to 5:00 p.m.
Monday through Friday
https://www.azahcccs.gov/shared/AHCCCScontacts.html#MemApp

Arkansas

Division of Medical Services
Donaghey Plaza South
P.O. Box 1437, Slot S401
Little Rock, AR 72203-1437
1-501-682-8292, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/

California

Medi-Cal
P.O. Box 997417, MS 4607
Sacramento, CA 95899-7417
1-916-552-9200, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Colorado

Health First Colorado
1570 Grant Street
Denver, CO 80203-1818
1-800-221-3943, TTY: **711**
8:00 a.m. - 4:30 p.m. Mon - Fri;
8:00 a.m. - 12:00 p.m. Sat
https://www.healthfirstcolorado.com/

Connecticut

Husky Health Connecticut
P.O. Box 5005
Wallingford, CT 06492
1-877-284-8759, TTY: **1-866-492-5276**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://www.ct.gov/hh/site/default.asp

Delaware

Delaware Medicaid
Lewis Building
1901 N. DuPont Highway
New Castle, DE 19720
1-800-372-2022, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://dhss.delaware.gov/dmma/

District of Columbia

DC Medicaid
441 4th Street, NW, 900S
Washington, DC 20001
1-202-442-5988, TTY: **711**
8:15 a.m. - 4:45 p.m. Monday through Friday
https://dhcf.dc.gov/service/medicaid

Florida

Statewide Medicaid Managed Care
2727 Mahan Drive, Mail Stop #8
Tallahassee, FL 32308
1-850-412-4000, TTY: **1-800-955-8771**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://ahca.myflorida.com/Medicaid/statewide_mc/index.shtml

Georgia

Georgia Medicaid
Georgia Department of Community Health
2 Peachtree Street, NW
Atlanta, GA 30303
1-877-423-4746, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://medicaid.georgia.gov/

Hawaii

Med-QUEST Division
P.O. Box 3490
Honolulu, HI 96811-3490
1-800-316-8005, TTY: **1-855-889-4325**
9:00 a.m. - 3:00 p.m. Monday through Friday
https://medquest.hawaii.gov/

Idaho

Idaho Medicaid
3232 Elder Street
Boise, ID 83705
1-877-456-1233, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://healthandwelfare.idaho.gov/services-programs/medicaid-health

Illinois

Illinois Medicaid
100 South Grand Avenue East
Springfield, IL 62762
1-800-226-0768, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
https://www2.illinois.gov/hfs/MedicalClients/Pages/default.aspx

Indiana

Indiana Medicaid
P.O. Box 7263
402 W Washington Street
Indianapolis, IN 46207-7263
1-800-457-4584, TTY: **711**
8:00 a.m. - 6:00 p.m. Mon - Fri
https://www.in.gov/medicaid/

Iowa

Iowa Medicaid
1305 East Walnut Street
Des Moines, IA 50319-0114
1-800-338-8366, TTY: **1-800-735-2942**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://hhs.iowa.gov/ime/about

Kansas

KanCare
P.O. Box 3599
Topeka, KS 66601
1-800-792-4884, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://www.kancare.ks.gov/

Kentucky

Kentucky Medicaid
275 East Main Street, 6W-A
Frankfort, KY 40621
1-855-306-8959, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

Louisiana

Louisiana Medicaid
P.O. Box 629
Baton Rouge, LA 70821-0629
1-888-342-6207, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://ldh.la.gov/subhome/1

Maine

MaineCare
109 Capitol Street
Augusta, ME 04333-0011
1-207-287-3707, TTY: **711**
7:00 a.m. - 6:00 p.m. Monday through Friday
https://www.maine.gov/dhhs/oms

Maryland

Maryland Medicaid Administration
201 West Preston Street
Baltimore, MD 21201
1-877-463-3464, TTY: **711**
8:30 a.m. - 5:00 p.m. Monday through Friday
https://health.maryland.gov/mmcp/pages/home.aspx

Massachusetts

MassHealth
One Ashburton Place, 11th Floor
Boston, MA 02108
1-800-841-2900, TTY: **1-800-497-4648**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.mass.gov/orgs/masshealth

Michigan

Michigan Medicaid
P.O. Box 30195
333 S. Grand Ave
Lansing, MI 48909
1-517-241-3740, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.michigan.gov/mdhhs/assistance-programs/medicaid

Minnesota

Minnesota's Medical Assistance Program
PO Box 64838
St. Paul, MN 55164
1-800-657-3739, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp#3

Mississippi

Mississippi Medicaid
550 High Street, Suite 1000
Jackson, MS 39201
1-800-421-2408, TTY: **1-228-206-6062**
7:30 a.m. - 5:00 p.m. Monday through Friday
http://www.medicaid.ms.gov

Missouri

MO HealthNet
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
1-573-751-3425, TTY: **711**
6:00 a.m. - 6:00 p.m. Monday through Friday
https://mydss.mo.gov/healthcare

Montana

Montana Medicaid and Healthy Montana Kids (HMK) Plus
P.O. Box 202925
Helena, MT 59620
1-888-706-1535, TTY: **711**
9:00 a.m. - 5:00 p.m. Monday through Friday
https://www.dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

Nebraska

Nebraska Medicaid
P.O. Box 95026
Lincoln, NE 68509-5026
1-855-632-7633, TTY: **1-800-833-7352**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dhhs.ne.gov/Pages/Medicaid-Services.aspx

Nevada

Nevada Medicaid
1100 East William Street, Suite 102
Carson City, NV 89701
1-877-638-3472, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
http://dhcfp.nv.gov/

New Hampshire

NH Medicaid
129 Pleasant Street
Concord, NH 03301
1-844-275-3447, TTY: **1-800-735-2964**
8:00 a.m. – 4:30 p.m. Monday through Friday
https://www.dhhs.nh.gov/programs-services/medicaid

New Jersey

NJ Medicaid
P.O. Box 712
Trenton, NJ 08625-0712
1-800-701-0710, TTY: **1-800-701-0720**
Monday and Thursday 8:00 a.m. - 8:00 p.m.
Tuesday, Wednesday, Friday 8:00 a.m. - 5:00 p.m.
https://www.state.nj.us/humanservices/dmahs/clients/medicaid/

New Mexico

Centennial Care
P.O. Box 2348
Santa Fe, NM 87504-2348
1-800-283-4465, TTY: **1-855-227-5485**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.hsd.state.nm.us/lookingforassistance/centennial-care-overview/

New York

New York State Medicaid
Corning Tower, Empire State Plaza
Albany, NY 12237
1-800-541-2831, TTY: **711**
8:00 a.m. - 8:00 p.m. Monday through Friday
9:00 a.m. - 1:00 p.m. Saturday
http://www.health.ny.gov/health_care/medicaid/

North Carolina

North Carolina Medicaid
2501 Mail Service Center
Raleigh, NC 27699-2501
1-888-245-0179, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://dma.ncdhhs.gov/

North Dakota

North Dakota Medicaid
600 E. Boulevard Avenue, Dept 325
Bismarck, ND 58505-0250
1-800-755-2604, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.hhs.nd.gov/healthcare-coverage/medicaid

Ohio

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, OH 43215
1-800-324-8680, TTY: **1-800-292-3572**
7:00 a.m. - 8:00 p.m. Monday through Friday
http://medicaid.ohio.gov/

Oklahoma

SoonerCare
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105
1-800-987-7767, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://oklahoma.gov/ohca.html

Oregon

The Oregon Health Plan (OHP)
P.O. Box 14015
Salem, OR 97309
1-800-699-9075, TTY: **711**
7:00 a.m. - 6:00 p.m. Monday through Friday
http://www.oregon.gov/oha/healthplan/pages/index.aspx

Pennsylvania

Pennsylvania Medical Assistance
Health and Welfare Building, Rm 515
P.O. Box 2675
Harrisburg, PA 17105
1-866-550-4355, TTY: **1-800-451-5886**
8:30 a.m. - 4:45 p.m. Monday through Friday
https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

Rhode Island

Rhode Island Medicaid
P.O. Box 8709
Cranston, RI 02920-8787
1-855-697-4347, TTY: **1-800-745-5555**
8:30 a.m. - 3:30 p.m. Monday through Friday
https://dhs.ri.gov/programs-and-services/medicaid-medicare-programs

South Carolina

Healthy Connections
P.O. Box 8206
Columbia, SC 29202
1-888-549-0820, TTY: **1-888-842-3620**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid
700 Governors Drive, Richard F. Kneip Building
Pierre, SD 57501
1-605-773-3165, TTY: **711**
8:00 a.m. - 6:00 p.m. Monday through Friday
http://dss.sd.gov/medicaid/

Tennessee

TennCare Medicaid
P.O. Box 305240
Nashville, TN 37230-5240
1-800-342-3145, TTY: **1-877-779-3103**
8:00 a.m. - 5:00 p.m. Monday through Friday
https://www.tn.gov/tenncare/members-applicants/eligibility/tenncare-medicaid.html

Texas

Texas Medicaid & CHIP
P. O. Box 13247
Austin, TX 78711-3247
1-800-252-8263, TTY: **1-512-424-6597**
7:00 a.m. - 7:00 p.m. Mon - Fri
https://www.hhs.texas.gov/services/health/medicaid-chip

Utah

Utah Medicaid
Division of Medicaid and Health Financing
P.O. Box 143106
Salt Lake City, UT 84114-3106
1-605-773-4678, TTY: **711**
8:00 a.m. - 5:00 p.m. Monday through Friday
(Thursday 11:00 a.m. - 5:00 p.m.)
https://medicaid.utah.gov/

Vermont

Green Mountain Care
280 State Drive
Waterbury, VT 05671-1010
1-800-250-8427, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
https://dvha.vermont.gov/members/medicaid

Virginia

Cardinal Care
600 East Broad Street
Richmond, VA 23219
1-833-522-5582, TTY: **1-888-221-1590**
8:00 a.m. - 7:00 p.m. Monday through Friday
https://www.dmas.virginia.gov/#/index

Washington

Apple Health
626 8th Avenue SE
Olympia, WA 98501
1-800-562-3022, TTY: **711**
7:00 a.m. - 5:00 p.m. Monday through Friday
http://www.hca.wa.gov/medicaid/Pages/index.aspx

West Virginia

West Virginia Medicaid
West Virginia Bureau for Medical Services
350 Capital Street, Room 251
Charleston, WV 25301-3709
1-304-558-1700, TTY: **711**
8:00 a.m. - 4:30 p.m. Monday through Friday
http://www.dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Wisconsin Medicaid
1 West Wilson Street
Madison, WI 53703
1-608-266-1865, TTY: **1-800-947-3529**
8:00 a.m. - 6:00 p.m. Monday through Friday
https://dhs.wisconsin.gov/medicaid/index.htm

Wyoming

Wyoming Medicaid
401 Hathaway Building
Cheyenne, WY 82002
1-800-251-1269, TTY: **1-307-777-7531**
9:00 a.m. - 5:00 p.m. Monday through Friday
https://health.wyo.gov/healthcarefin/medicaid/

SECTION 4 State Medicare Offices

The following state agency information was updated on 06/01/2023. For more recent information or other questions, please contact Member Services.

All 50 U.S. States and Washington, D.C.

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
24 hours, 7 days a week
www.medicare.gov

SECTION 5 Civil Rights Commission

The following state agency information was updated on 06/01/2023. For more recent information or other questions, please contact Member Services.

Alabama

Office for Civil Rights of the Southeast Region – Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Alaska

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arizona

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Arkansas

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

California

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Colorado

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Connecticut

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Delaware

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. to 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

District of Columbia

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. to 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Florida

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Georgia

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Hawaii

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Idaho

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Illinois

Office for Civil Rights of the Midwest Region
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Indiana

Office for Civil Rights of the Midwest Region
233 N. Michigan Ave., Suite 240
Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
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Iowa

Office for Civil Rights of the Midwest Region
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Chicago, IL 60601
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Kansas

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FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kentucky

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Louisiana

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maine

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Maryland

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. to 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Massachusetts

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
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Michigan

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Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
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Minnesota

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Chicago, IL 60601
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
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Mississippi

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
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FAX: **1-202-619-3818**
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Missouri

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FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Montana

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nebraska

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Chicago, IL 60601
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FAX: **1-202-619-3818**
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http://www.hhs.gov/ocr

Nevada

Office for Civil Rights of the Pacific Region
90 7th Street, Suite 4-100
San Francisco, CA 94103
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
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New Hampshire

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Jersey

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Mexico

Office for Civil Rights of the Southwest Region
1301 Young Street, Suite 106
Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
7:30 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

New York

Office for Civil Rights of Eastern and Caribbean Region
26 Federal Plaza, Suite 3312
New York, NY 10278
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Carolina

Office for Civil Rights of the Southeast Region - Atlanta
Sam Nunn Atlanta Federal Center, Suite 16T70
61 Forsyth Street, SW
Atlanta, GA 30303-8909
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

North Dakota

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
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Ohio

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Oklahoma

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Oregon

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San Francisco, CA 94103
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FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Pennsylvania

Office for Civil Rights of the Mid-Atlantic Region
801 Market Street, Suite 9300
Philadelphia, PA 19107-3134
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
9:30 a.m. to 3:30 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Rhode Island

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 02203
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
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South Carolina

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Atlanta, GA 30303-8909
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FAX: **1-202-619-3818**
8:00 a.m. to 4:30 p.m.
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South Dakota

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Denver, CO 80294
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Tennessee

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Texas

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Utah

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FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
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Vermont

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Boston, MA 02203
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FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
Email: ocrmail@hhs.gov
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Virginia

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FAX: **1-202-619-3818**
9:30 a.m. to 3:30 p.m.
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Washington

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San Francisco, CA 94103
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FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
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West Virginia

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FAX: **1-202-619-3818**
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Wisconsin

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Chicago, IL 60601
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FAX: **1-202-619-3818**
8:30 a.m. to 5:00 p.m.
Email: ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wyoming

Office for Civil Rights of Rocky Mountain Region
1961 Stout Street, Room 08-148
Denver, CO 80294
1-800-368-1019, TTY: **1-800-537-7697**
FAX: **1-202-619-3818**
8:00 a.m. to 8:00 p.m.
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Form Approved
OMB# 0938-1421

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at the phone number listed on your plan membership card (TTY: **711**). Someone who speaks your language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al número de teléfono que figura en su tarjeta de miembro del plan (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 您计划会员卡上的电话号码 (TTY: **711**)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 您計劃會員卡上的電話號碼 (TTY: **711**)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa numero ng telepono na nakalista sa iyong membership card ng plano (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au numéro de téléphone inscrit sur votre carte de membre (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi số điện thoại có trên thẻ hội viên chương trình của quý vị (TTY: **711**), sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí.

German: Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter der auf Ihrer Plan-Mitgliedskarte (TTY: **711**) angegebenen Telefonnummer. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 플랜 가입자 카드에 기재된 전화번호(TTY: **711**)로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по номеру телефона, указанному на вашей карте участника плана (TTY: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا.
للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على رقم الهاتف المدرج في بطاقة العضوية التابعة لخطتك (TTY: **711**).سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية .

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें आपके प्लान सदस्यता कार्ड पर दिए गए नंबर पर (TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero di telefono presente sulla vostra tessera di adesione al piano (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número de telefone indicado no seu cartão de membro do plano (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan nimewo telefòn ki endike sou kat manm plan w lan (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer telefonu podany na karcie członka planu (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため の無料の通訳サービスをご利用いただけます。通訳を希望される場合は、プランの会員証に記載されている電話番号 (TTY: **711**) にお電話ください。日本語を話す者 が対応いたします。これは無料のサー ビスです。

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Member Services - Contact Information

Call:	1-855-251-8825. Calls to this number are free. Monday through Friday, 8 a.m. to 9 p.m. ET, except holidays Member Services 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.
Fax:	1-844-470-8861
Write:	Anthem Medicare Preferred (PPO) P.O. Box 173144 Denver, CO 80217-3144
Website:	www.anthem.com/ca/calpers

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. See the "State organization contact information" chapter located at the back of this document to find the information for your state.