Evidence of Coverage

Effective January 1, 2026

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, 2026 - December 31, 2026

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

This document gives the details of your Medicare health coverage from January 1, 2026 – December 31, 2026. **This is an important legal document. Keep it in a safe place.**

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

- Our plan premium and cost sharing
- Our medical benefits
- How to file a complaint if you're not satisfied with a service or treatment
- How to contact us
- Other protections required by Medicare law

For questions about this document, call Member Services at **1-855-251-8825**. (TTY users 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.

Our provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

YOUR MEDICAL 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 2026 Medical Benefits Chart
PPO Plan 10PH
CalPERS

The benefits and description of covered services, including preferred brands or vendors, within this summary are pending final Plan and CMS approval and may change.

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	
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're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include but aren't 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)	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan.	For Medicare-covered hospital stays: $0 copay per admission No limit to the number of days covered by the plan.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
• 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're admitted as an inpatient to a hospital for special care)	$0 copay for Medicare-covered physician services received while an inpatient during a Medicare-covered hospital stay	$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
• 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'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're 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 our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll 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. Our plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center with the dates you were treated as an outpatient and required to be near the Medicare-approved transplant center to receive treatment/ services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Member Services. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website **www.gsa.gov**. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please see the Asking us to pay our share of a bill for covered medical services chapter in your EOC.		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
• Blood – including storage and administration. Coverage of whole blood, packed red cells, and all other components of blood starts with the first pint. • Physician services 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're not sure if you're an inpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at **https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-800-486-2048**.		
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 Definitions 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 aren't 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 our 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		
Generally, you get SNF care from plan facilities. 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		

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
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.		
Inpatient services you get when the hospital or SNF days are not covered or are no longer covered* If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or a skilled nursing facility (SNF). Covered services include, but aren't 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	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.	
Home health agency care* Before you get 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 aren't limited to:	$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**
• 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		
Hospice care You're 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 can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including programs we own, control, or have a financial interest in. Your hospice doctor can be an in-network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you're admitted to a hospice you have the right to stay in our plan; if you chose to stay in our plan you must continue to pay plan premiums. **For hospice services and for services that are covered by Medicare Part A or B that are related to your terminal prognosis**: Original Medicare (rather than our 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're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. **For services covered by Medicare Part A or B not related to your terminal prognosis**: If you need nonemergency,	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**
nonurgently needed services covered under Medicare Part A or B that aren't 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 (like if there's a requirement to get prior authorization). • If you get the covered services from an in-network provider and follow the plan rules for obtaining service, you only pay our plan cost-sharing amount for in-network services. • If you get the covered services from an out-of-network provider, you pay the cost sharing under Original Medicare. **For services that are covered by our plan but not covered by Medicare Part A or B**: Our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our 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's not related to your terminal prognosis), contact us to arrange the services.		
Outpatient services		
Physician services, including doctor's office visits* Covered services include: • Medically necessary medical care or surgery services you get 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 evaluations performed by your Primary Care Physician or specialist, if your doctor orders it to see if you need medical treatment, are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered services $10 copay per visit to an in-network specialist for Medicare-covered services	$10 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered services $10 copay per visit to an out-of-network specialist for Medicare-covered services

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
• Certain telehealth services for some physician or mental health services can be found in the section of this benefits chart titled, Video doctor visits ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • 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 • 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 getting 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	$10 copay per visit to an in-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $0 copay for Medicare-covered allergy injections See antigen cost share in Part B drug section.	$10 copay per visit to an out-of-network retail health clinic for Medicare-covered services $0 copay for Medicare-covered allergy testing $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**
• 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 • In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ 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
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than three months). Services may include pain assessment, medication management, and care coordination and planning.	$10 copay per visit to an in-network Primary Care Physician (PCP) for Medicare-covered chronic pain management visit	$10 copay per visit to an out-of-network Primary Care Physician (PCP) for Medicare-covered chronic pain management visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
	$10 copay per visit to an in-network specialist for Medicare-covered chronic pain management visit Cost sharing for this service will vary depending on individual services provided under the course of treatment	$10 copay per visit to an out-of-network specialist for Medicare-covered chronic pain management visit Cost sharing for this service will vary depending on individual services provided under the course of treatment
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered 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 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**
• A master's 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
Outpatient mental health care, including partial hospitalization services and intensive outpatient 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), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed	$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 partial hospitalization and intensive outpatient services 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 partial hospitalization 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**
marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. 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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor'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 group therapy visit $0 copay for each Medicare-covered partial hospitalization facility 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 group therapy visit $0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit
Outpatient substance use disorder services, including partial hospitalization services and intensive outpatient services* Partial hospitalization is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. 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's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	$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 partial hospitalization and intensive outpatient services visit $0 copay for each Medicare-covered outpatient hospital facility 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 partial hospitalization and intensive outpatient services visit $0 copay for each Medicare-covered outpatient hospital facility individual therapy visit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
	$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 outpatient hospital facility group therapy visit $0 copay for each Medicare-covered partial hospitalization facility and intensive outpatient services visit
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're having surgery in a hospital, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're 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. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at **https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**.	$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
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 Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests.	$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 out-of-network primary care physician in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're 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're not sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet Medicare Hospital Benefits. This fact sheet is available at **https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048.**	$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 specialist in an outpatient hospital setting/ clinic for Medicare-covered non-surgical services $0 copay for each Medicare-covered outpatient observation room visit
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 if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. • If the covered ambulance services aren't 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	
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.	$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
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're 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's quickly getting worse. This coverage is worldwide and is limited to what's allowed under the Medicare fee schedule for the services performed/ received in the United States. Please refer to the Foreign travel emergency and urgently needed services benefit section for cost sharing and limits outside of the United States or its territories. Cost sharing for necessary emergency services you get out-of-network is the same when you get these services 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.		
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. A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside the service area or our plan network is temporarily unavailable.	$25 copay for each Medicare-covered urgently needed care visit	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
This coverage is worldwide and is limited to what's allowed under the Medicare fee schedule for the services performed/ received in the United States. Please refer to the Foreign travel emergency and urgently needed services benefit section for cost sharing and limits outside of the United States or its territories.		
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
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. Our 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	$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**
• 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.		
Durable medical equipment (DME) and related supplies* (For a definition of durable medical equipment, see the Definitions of important words chapter in your EOC.) Covered items include, but aren't 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. 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 DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you can 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 isn't NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. This plan only covers FreeStyle Libre® (made by Abbott) and Dexcom Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. Coverage is limited to two to three sensors per month, depending on the receiver, and one receiver every two years.	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen 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. $0 copay for Medicare-covered CGMs and related supplies	10% coinsurance for Medicare-covered DME including oxygen supplies and oxygen 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. $0 copay for Medicare-covered CGMs and related supplies

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
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.	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.
Prosthetic and orthotic devices and related supplies* Devices (other than dental) that replace all or a body part or function. These include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: 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 and orthotic devices and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery - go to Vision care later in this benefits chart for more detail.	10% coinsurance for Medicare-covered prosthetic and orthotic devices	10% coinsurance for Medicare-covered prosthetic and orthotic devices
Home infusion therapy* Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person 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 aren't limited to: • Professional services, including nursing services, furnished in accordance with our 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:	$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**
• 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		
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 • For people with diabetes who have severe diabetic foot disease: 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). Coverage includes 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 FreeStyle® (made by Abbott) and ACCU-CHEK® (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 FreeStyle® (made by Abbott) and ACCU-CHEK® (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 FreeStyle® (made by Abbott) and ACCU-CHEK® (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 FreeStyle® (made by Abbott) and ACCU-CHEK® (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**
	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 See the Durable Medical Equipment (DME) benefit section for continuous glucose monitors (CGMs) cost sharing.	**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 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*		
Covered services include, but aren't 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 • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem • 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 each Medicare-covered X-ray visit and/or simple diagnostic test $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 for each Medicare-covered hemoglobin A1c or urine tests to check albumin levels $0 copay per Medicare-covered pint of blood	$0 copay for each Medicare-covered X-ray visit and/or simple diagnostic test $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 for each Medicare-covered hemoglobin A1c or urine tests to check albumin levels $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 get 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 disorder 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
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 for glaucoma, we 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 can't 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	$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

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
	20% coinsurance for glasses/ contacts following Medicare-covered cataract surgery	20% coinsurance for glasses/ contacts following Medicare-covered cataract surgery
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. Our 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 people (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. In addition, we cover a bone mass measurement post fracture. Recommendation is to get a bone mass measurement within six months of fracture, which may help reduce risk of additional fractures in the future.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement or a bone mass measurement after a fracture.	There is no coinsurance, copayment, or deductible for the Medicare-covered bone mass measurement or a bone mass measurement after a fracture.

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 aren't at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, coverage for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • 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 computed tomography colonography. • 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. • Include the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam • 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.	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 tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.		
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you 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.
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the Medicare-covered PrEP benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered PrEP benefit.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
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 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.
Medicare Part B immunizations **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.** Covered services include: • Pneumonia vaccines • Flu/influenza shots, (or vaccines), including H1N1, once each flu season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage 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.	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.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
Cervical and vaginal cancer screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you're at high risk of cervical or vaginal cancer or you're 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.
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 screening tests 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 Our 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 preventive services you need (including certain screenings and shots (or vaccines)), 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 want 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.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these 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. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	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.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people 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 (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.
Screening for Hepatitis C virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.		
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are:** people age 50 – 77 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 get an 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 members must get an 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 later 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 the first year that you get 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 get 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 stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover two cessation attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with the patient getting up to eight sessions per year.)	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.
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 Medicare Part B. For information about coverage for Part B drugs, go to Medicare Part B drugs in this benefits chart.	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 $0 copay for Medicare-covered self-dialysis training	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 $0 copay for Medicare-covered self-dialysis training

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
	10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies	10% coinsurance for Medicare-covered home dialysis equipment and supplies 10% coinsurance for Medicare-covered outpatient dialysis equipment and supplies
Medicare Part B drugs* These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs include substances that are naturally present in the body, such as blood clotting factors • Drugs that usually aren't self-administered by the patient and are injected or infused while you get 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 our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia	20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration 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	20% coinsurance for Medicare-covered Part B drugs 20% coinsurance for Medicare-covered Part B drug administration 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**
• Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis and can't self-administer the drug • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home and outpatient dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, or Methoxy polyethylene glycol-epoetin beta Mircera®)	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**
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) 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 our Part D prescription drug and vaccine benefits.**		
Additional supplemental benefits, services, and discounts		
Routine hearing services This plan provides additional hearing coverage not covered by Original Medicare. • 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 TruHearing. 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.	Must use a TruHearing 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 TruHearing. $0 copay for routine hearing exams $0 copay for hearing aid fitting evaluations $0 copay for hearing aids through TruHearing

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**
We have partnered with TruHearing 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 TruHearing. They will send the hearing aid(s) directly to your provider. Hearing Aids must be supplied by the plan's hearing network vendor, TruHearing. The plan does not reimburse for devices received from other vendors or providers under this supplemental benefit. For more information on your benefit, covered devices or to locate a TruHearing provider please contact TruHearing at **1-855-312-2545**. Hearing benefit management administered by TruHearing, 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.	Hearing aid must be ordered through TruHearing and selected from the list of available devices. TruHearing will send the device directly to your provider. 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 This plan provides additional vision coverage not covered by Original Medicare. • Routine vision exams Routine vision exams, including a refraction, are limited to one every calendar year combined in-network and out-of-network. 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.	Must use a Blue View Vision provider. $10 copay for routine vision exams After the plan pays benefits for routine vision exams, you are responsible for any remaining cost.	$10 copay for routine vision exams 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**
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 Blue View Vision Out-of-Network Claim Form for reimbursement up to your maximum out-of-network allowance. In-network benefits and discounts will not apply.	Any in-store promotions or discounts cannot be combined with your Blue View Vision benefit and discount.	
Routine foot care This plan provides additional foot care coverage not covered by Original Medicare. • 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
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 health plan ID 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 ID card ready when you sign up. **Benefits of a video doctor visit:**	$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
• 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. LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health 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.		
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	$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
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 **1-855-741-4985 (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. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.		
24/7 NurseLine 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)	$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
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.		
Medicare Community Resource Support Need help with a specific issue? While your plan includes Medicare benefits along with the extra benefits outlined in this benefits chart, you may sometimes require more support. As a member, you have access to our Medicare Community Resource Support team. They are here to help you find community-based services and support programs in your area. To use this benefit, contact Member Services at the number on the back of your member ID card, and ask for the Medicare Community Resource Support team.	$0 copay for Medicare Community Resource Support	
Healthy Meals* Provides up to 14 meals per qualifying event, allows up to four (4) events each year (56 meals in total). A portion of this benefit may be used to obtain meal replacement shakes. • A qualifying event includes when you are in a hospital or a skilled nursing facility and are discharged home. • This benefit also qualifies as a Special Supplemental Benefit for the Chronically Ill (SSBCI). You may qualify for SSBCI if you have a high risk for hospitalization and require intensive care coordination to manage chronic conditions such as Chronic Kidney Diseases, Chronic Lung Disorders, Cardiovascular Disorders, Chronic Heart Failure, or Diabetes. • For a full list of chronic conditions or to learn more about other eligibility requirements needed to qualify for SSBCI benefits, please refer to Chapter 4 in your plan's Evidence of Coverage.	$0 copay for Healthy Meals	

Services that are covered for you	What you must pay when you receive these services	
	In-Network	Out-of-Network
• Chronic condition meals, must be ordered or approved by a healthcare provider, and you must be part of a supervised program designed to transition you to a healthier lifestyle. You, or your provider can contact Member Services on the back of your member ID card and a representative will help with the process to validate you qualify for the benefit. If you qualify, we or an approved vendor acting on our behalf may contact you at the number you provided, to confirm shipping details and any nutritional requirements. We are unable to initiate your chronic condition meals without speaking to you. By requesting this benefit you are expressly authorizing us to contact you by telephone.		
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 device please call Member Services.	$0 copay for personal emergency response system	
Routine transportation • Routine transportation covers up to 12 non-emergency one-way trips each year, to locations within the local service area, when obtaining plan-approved health related services. A trip is limited to 60 miles per one-way trip. • Trips can be used for getting to and from plan-approved medical-related visits, SilverSneakers locations, and visits to a pharmacy to pick up prescriptions. You can use this benefit for one-way trips or you can schedule a round trip by using two one-way trips. Short stops at a pharmacy to pick up a prescription, after a plan-approved medical-related visit, can be made as part of the return trip and will not require a separate trip. Ask the provider/facility to call in the prescription, so you have a shorter wait.	$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**
• You must schedule trips at least 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. • Modes of approved transportation may include taxi, rideshare, wheelchair van and public transportation. • Trips will not be covered for personal errands or other reasons when accessing non-covered services. We have partnered with MTM Health to bring you these discounts and services. You must use the plan approved vendor. For more information about this benefit please contact Member Services or to schedule a trip contact MTM Health at (888) 479-3249. Please refer to the Ambulance services section in this benefits chart for information on non-emergency Medicare-covered ambulance services. MTM Health, an independent company, is providing routine transportation on behalf of the plan.		
Additional acupuncture services This plan provides additional acupuncture coverage not covered by Original Medicare. Coverage includes acupuncture services, not covered by Medicare, rendered by a licensed acupuncturist to treat a disease, illness or injury. Your treatment plan may require verification of medical necessity. 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 more information about this benefit please contact Member Services.	$10 copay per visit After the plan pays benefits for additonal acupuncture services and additional chiropractic services, you are responsible for any remaining cost.	$10 copay per visit After the plan pays benefits for additonal acupuncture services and additional chiropractic 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**
Additional chiropractic services This plan provides additional chiropractic coverage not covered by Original Medicare. Coverage includes chiropractic services, not covered by Medicare, rendered by a physician to treat a disease, illness or injury. Your treatment plan may require verification of medical necessity. 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 more information about this benefit please contact Member Services.	$10 copay per visit After the plan pays benefits for additional chiropractic services and additional acupuncture services, you are responsible for any remaining cost.	$10 copay per visit After the plan pays benefits for additional chiropractic services and additional acupuncture services, you are responsible for any remaining cost.
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.	
Medical travel benefit* Travel and lodging coverage for eligible medically necessary services, including abortion services, gender-affirming care, complex surgeries, bariatric surgery, and cancer care that cannot be accessed within 50 miles from your residence. This includes transportation, lodging, and meals for you and your companion.	$0 copay for medical travel benefit	$0 copay for medical travel benefit

Services that are covered for you	What you must pay when you receive these services	
	In-Network	**Out-of-Network**

• Reasonable meals, lodging and transportation costs to obtain the necessary services, will be reimbursed consistent with current IRS guidelines and coverage limits.
• Accommodations for lodging will be reimbursed at the lesser of:
  • billed charges, or
  • $50 per day per covered person up to a maximum of $100 per day per covered person consistent with IRS guidelines
• Issuance of a 1099 form may be applicable.
 	
Medical travel benefit is limited to a maximum benefit of $5,000 per occurrence combined in-network and out-of-network.
	After the plan pays benefits for medical travel benefit, you are responsible for any remaining cost.	After the plan pays benefits for medical travel benefit, you are responsible for any remaining cost.

Maximum out-of-pocket amount 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.

2026 Evidence of Coverage

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Anthem Medicare Preferred (PPO)

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

You're covered by Medicare, and you chose to get your Medicare health coverage through our plan, Anthem Medicare Preferred (PPO). Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different 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 doesn't include Part D drug coverage.

Section 1.2 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 get 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.

Medicare allows us to make changes to plans we offer each calendar year. This means we can change the costs and benefits of your plan after December 31, 2026, or on your group-sponsored plan's renewal date. We can also choose to stop offering our plan in your service area, after December 31, 2026.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B.
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered in the geographic service area even if they're physically located in it.
- You're a United States citizen or 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 Plan service area for our plan

Our plan is only available to people who live in our geographic service area. To stay a member of our plan, you must continue to live 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 move out of our plan's service area, you can't stay a member of this plan. Call 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.

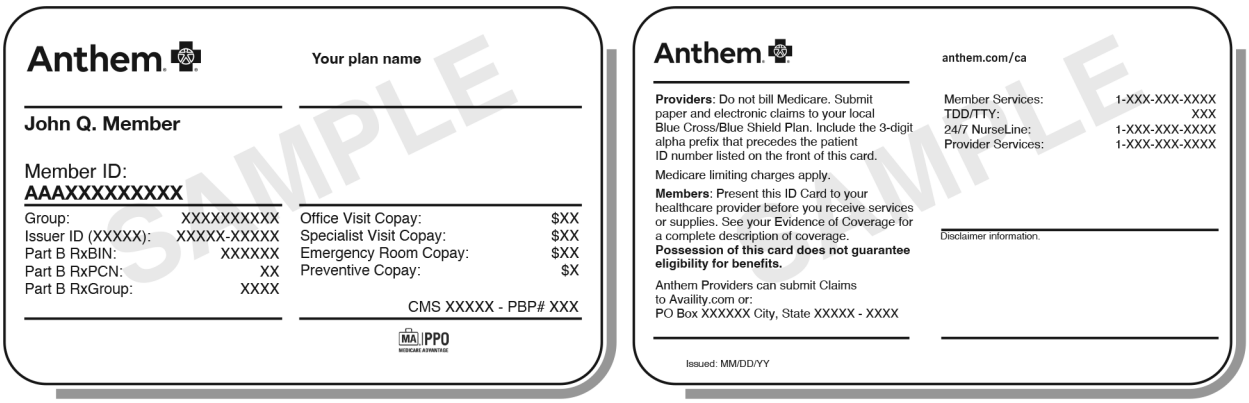
Section 2.4 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Anthem Medicare Preferred (PPO) if you're not eligible to stay a member of our plan on this basis. Anthem Medicare Preferred (PPO) must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our member ID card

Use your member ID card whenever you get services covered by our plan. Sample ID card:



DON'T use your red, white and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your ID 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 our ID card is damaged, lost or stolen, call Member Services right away and we'll send you a new card. You can also log into **www.anthem.com/ca/calpers** to print temporary ID 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.

As a member of our plan, you can choose to get 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. Go to Chapter 3, and Chapter 4, for more specific information.

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 a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services. Requested paper Provider Directories will be mailed to you within 3 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).

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 Summary of Important Costs for 2026

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)

Section 4.1 Plan premium

Your coverage is provided through a contract with your group sponsor. 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, contact Member Services.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of Medicare & You 2026 handbook, the section called 2026 Medicare Costs. If you need a copy you can download it from the Medicare website (**www.medicare.gov/medicare-and-you**). Or, you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Section 4.2 Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

You must continue paying your Medicare premiums to stay a member of our plan.

This includes your premium for Part B. You may also pay a premium for Part A if you 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 2026* handbook, the section called "2026 Medicare Costs." If you need a copy you can download it from the Medicare website (**www.medicare.gov/medicare-and-you**). Or, you can order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

SECTION 5 Our monthly plan premium won't change 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 6 Keep our plan membership record up to date

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

The doctors, hospitals and other providers **use your membership record to know what services are covered and the cost sharing amounts.** Because of this, it is very important to help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your group sponsor, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident
- If you're admitted to a nursing home
- If you get 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 participate in a clinical research study (Note: You're not required to tell our plan about clinical research studies you intend to participate in but we encourage you to do so).

If any of this information changes, 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's also important to contact Social Security if you move or change your mailing address. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical coverage you have in addition to this retiree coverage. We can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits.**

Once a year, we'll send you a letter that lists any other medical coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that is not listed, call Member Services. You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

When you have other insurance, Medicare rules decide whether our plan or your other insurance pays first. The insurance that pays first (the "primary payer"), pays up to the limits of its coverage. The insurance that pays second, (the "secondary payer"), only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all 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) are 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 has more than 100 employees.
    - If you're over 65 and you (or your spouse or domestic partner) are 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 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:

Phone numbers and resources

SECTION 1 Your plan contacts

For help with claims, billing, or member card questions, call or write to Member Services. We'll be happy to help you.

	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 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 ask 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 pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care, go to Chapter 7.

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

	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

	Coverage Decisions for Medical Care – Contact Information
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties 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**

	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 make 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 7.

	Complaints – 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 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	To submit a complaint about your plan directly to Medicare, go to **www.Medicare.gov/my/medicare-complaint**.

How to ask us to pay our share of the cost for medical care you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, go to Chapter 5 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 7 for more information.

	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 hearing or speaking. Calls to this number are free.

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

SECTION 2 Get help from Medicare

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 ("CMS"). This agency contracts with Medicare Advantage organizations including our plan.

	Medicare – Contact Information
Call	**1-800-MEDICARE**, (**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 hearing or speaking. Calls to this number are free.
Chat Live	Chat Live at **Medicare.gov/talk-to-someone**
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	**www.Medicare.gov** • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities,

	Medicare – Contact Information
	hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about your plan. To submit a complaint to Medicare, go to **www.Medicare.gov/my/medicare-complaint**

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your medicare questions. SHIP is an independent state program (not connected with any insurance company or health plan) 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, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, 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, 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 (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare 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 paid by Medicare to check on and help improve the quality of care for people with Medicare. It is an independent organization. It's not connected with our plan.

Contact the QIO in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis
- 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, refer to the state-specific agency listing located in the QIO section of Chapter 11 in this document.

SECTION 5 Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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

	Social Security – Contact Information
Call	**1-800-772-1213** Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. 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 a.m. to 7 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.

Medicaid offers programs to 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.

To find out more about Medicaid and Medicare Savings Programs, please refer to the state-specific agency listing, which is located in the Medicaid section of Chapter 11 in this document.

SECTION 7 Railroad Retirement Board (RRB)

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 get your Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

	Railroad Retirement Board (RRB) – Contact Information
Call	**1-877-772-5772** Calls to this number are free. Press "0", to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. Press "1", to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov/**

SECTION 8 If 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 our plan for your medical services

SECTION 1 How to get medical care as a member of our plan

This chapter explains what you need to know about using the 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 the plan.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart located at the front of this document and Chapter 4.

Section 1.1 "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 services and care. 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 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 Medical Benefits Chart located at the front of this document.

Section 1.2 Basic rules for your medical care to be 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 get is included in our plan's Medical Benefits Chart.** This chart is located at the front of this document.
- **The care you get 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 get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either an in-network provider or an out-of-network provider. (Go to Section 2 for more information).
    - The providers in our network are listed in the Provider Directory.

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 can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

SECTION 2 Use in-network and out-of-network providers to get 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. For example:

- 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. Refer to your Medical 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.

When a specialist or another in-network provider leaves your plan?

We may make changes to the hospitals, doctors and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask, to continue getting, medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network, at in-network cost sharing.
- If you find out that your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality of care grievance to our plan, or both. Go to Chapter 7.

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

As a member of your plan, you can choose to get care from out-of-network providers. However, providers that don't 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 more 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 can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don’t need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary. Go to Chapter 7, Section 4 for information about asking for coverage decisions. This is important because:

- Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or were not medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care. Go to Chapter 7, to learn how to make an appeal.

- It's best to ask an out-of-network provider to bill your local Blue Plan first. But if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or, if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 5).
- 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 in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical 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're 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's 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 don't need to get approval or a referral first from your provider. You don't need to use a network doctor. You can 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're not part of our network.
- **As soon as possible, notify us of your emergency by calling Member Services.**

Covered services in 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. Refer to the Medical Benefits Chart located at the front of this document for additional information.

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

After the emergency is over, you're 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 wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

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

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

Your plan may cover urgently needed services outside of the United States and its territories. Refer to the Medical Benefits Chart located at the front of this document for additional information.

Section 3.3 Get 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're still entitled to care from our plan.

Visit **www.anthem.com/ca/calpers** for information on how to get needed care during a disaster.

SECTION 4 What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 5 for information about what to do.

Section 4.1 If services are not covered by our plan, you must pay the full cost

Your plan covers all medically necessary services as listed in the Medical Benefits Chart located at the front of this document. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

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

SECTION 5 Medical services 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 ask for 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. When you’re in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that’s not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, then you're 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'll reimburse the difference between what you paid and the in-network cost sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from your plan. The providers that deliver your care as part of the clinical research study don't need to be part of our plan’s network of providers. (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules).

While you don't need our plan’s permission to be in a clinical research study, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare you'll be responsible for paying all costs for your participation in the study.

Section 5.2 Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get 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's part of the research study.
- Treatment of side effects and complications of the new care.

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these

services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 5 for more information on submitting requests for payments.

Example of cost sharing in a clinical trial:

Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation, (like a provider bill), to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

When you're in a clinical research study, neither Medicare nor our plan will pay for any of the following:

- Generally, Medicare won't pay for the new item or service the study is testing unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free-of-charge for people in the trial.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication "*Medicare and Clinical Research Studies*" available at: **www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**.) You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

SECTION 6 Rules for getting care in a "religious non-medical health care institution"

Section 6.1 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'll instead cover 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 How to get 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're conscientiously opposed to getting medical treatment that is "non-excepted."

- **Non-excepted** medical care or treatment is any medical care or treatment that's *voluntary* and *not required* by any federal, state or local law.

- **Excepted** medical treatment is medical care or treatment you get that's *not* voluntary or *is required* under federal, state, or local law.

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – *and* – you must get approval in advance from our plan before you're admitted to the facility or your stay won't be covered.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like 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 members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME 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 get ownership of the item.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards 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 don't 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.

For example, you made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn’t get ownership of the item while in our plan. You then go back to Original Medicare. You’ll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don’t count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

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, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-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, your primary physician 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 ID 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's 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. This section also gives information about medical services that aren't covered and about limits on certain services.

Section 1.1 Out-of-pocket costs you may pay for covered services

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

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share. Section 1.2 explains more about your yearly deductible.
- **Copayment:** the fixed amount you pay each time you get 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 tells you more about our copayments.
- **Coinsurance:** 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 tells 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, go to Chapter 4, Section 1.3.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs be sure to show our proof of Medicaid or QMB eligibility to our provider.

Section 1.2 Our plan deductible

Refer to the Medical Benefits Chart located at the front of this document to determine if your plan has an annual deductible.

Until you've paid the deductible amount, you must pay the full cost for most of your covered services. After you pay your deductible, we'll start to pay our share of the costs for covered medical services and you'll pay your share for the rest of the plan year.

The deductible doesn't apply to some services, including certain in-network preventive services. This means that we'll pay our share of the costs for these services even if you haven't paid your deductible yet. Refer to the Medical Benefits Chart located at the front of this document to determine which services aren't subject to your plan deductible.

Section 1.3 What's the most you'll pay for Medicare Part A and Part B covered medical services?

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

- Your **combined maximum out-of-pocket amount** is located on the Medical 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 our plan premiums don't count toward your combined maximum out-of-pocket amount. If you pay the amount located on the Medical Benefits Chart at the front of this document for covered services, you'll have 100% coverage and won't 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 our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party). Refer to the Medical 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 (described above), you may also have a separate maximum out-of-pocket amount that applies only to certain types of medical services. Refer to the Medical 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 Providers aren't allowed to "balance bill" you

As a member of our plan, you have an important protection because after you meet any deductibles, you only have to pay your cost sharing amount when you get services covered by our plan. Providers can't bill you for 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's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), 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), you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you get the covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, this is set in the contract between the provider and our plan.
    - If you get 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 get the covered services from an out-of-network DME supplier who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
    - If you get the 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 isn't enrolled with Medicare, either as a Medicare participating provider or a non-participating Medicare provider.
- If you think a provider has balance billed you, call Member Services.

SECTION 2 The Medical Benefits Chart located at the front of this document, along with this chapter, shows your medical benefits and costs

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 these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services, including medical care, services, supplies, equipment, and Part B 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.
    - For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some services listed in the Medical Benefits Chart are covered as in-network services only if your doctor or other in-network provider gets approval from us in advance. This is sometimes called "prior authorization."
    - Covered services that need approval in advance to be covered for both in and out of network providers are identified in the Medical Benefits Chart.

- Prior authorization is required for these services for both in and 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 get the services from as noted below:
  - If you get the covered services from an in-network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate, (this is set in the contract between the provider and our plan).
  - If you get 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 get 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 get covered services from an out-of-network DME supplier who doesn't participate with Medicare, then you pay the coinsurance amount multiplied by the total charge of the non-participating provider's bill.
  - If you get 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 isn't 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*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **www.Medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.)
- For preventative services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you get the preventative service, a cost share may apply for the care you got for the existing medical condition medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

Important Benefit Information for Enrollees with Chronic Conditions and Special Supplemental Benefits for the Chronically Ill.

Some plans may include Special Supplemental Benefits for the Chronically Ill (SSBCI), as defined by the Centers for Medicare & Medicaid Services (CMS). Per CMS guidelines, If you're diagnosed with one or more of the chronic condition(s) identified below and your condition:

(1) Is life threatening or significantly limits your overall health or function; AND

(2) Has a high risk of hospitalization of other adverse health outcomes; AND

(3) Requires intensive care coordination

You may be eligible for special supplemental benefits for the chronically ill.

Meeting these conditions must be demonstrated by one or more of the following:

- One or more inpatient admissions (inclusive of behavioral health) related to the chronic condition in the last 12 months, OR
- One or more urgent care or emergency room visits related to the chronic condition in the last 12 months, OR
- Two or more outpatient visits related to the chronic condition (including primary care or specialty care visits) in the last 12 months, OR
- Is a patient who requires home health visits related to the chronic condition, OR
- Is a patient who has an impairment in daily living activities related to the chronic condition (bathing, dressing, toileting, transferring, and eating) or cognitive impairments, OR
- Is a patient with a chronic condition and a need for one or more durable medical equipment (DME) in the outpatient setting (including but not limited to): group 3 power / manual wheelchair, non-invasive ventilation (NIV), wound vacuums, bipap machines, mechanical in-exsufflation devices, group 2 or group 3 mattresses

Eligible Conditions:

- Chronic alcohol use disorder and other substance use disorders;
- Autoimmune disorders:
  - Polyarteritis nodosa,
  - Polymyalgia rheumatica,
  - Polymyositis,
  - Dermatomyositis
  - Rheumatoid arthritis,
  - Systemic lupus erythematosus,
  - Psoriatic arthritis, and
  - Scleroderma;
- Cancer;
- Cardiovascular disorders:
  - Cardiac arrhythmias,

  - Coronary artery disease,Peripheral vascular disease, and
  - Valvular heart disease;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
  - Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%)
- Overweight, Obesity, and Metabolic Syndrome;
- Chronic gastrointestinal disease:
  - Chronic liver disease,
  - Non-alcoholic fatty liver disease (NAFLD),
  - Hepatitis B,
  - Hepatitis C,
  - Pancreatitis,
  - Irritable bowel syndrome, and
  - Inflammatory bowel disease;
- Chronic kidney disease (CKD):
  - CKD requiring dialysis/End-stage renal disease (ESRD), and
  - CKD not requiring dialysis;
- Severe hematologic disorders:
  - Aplastic anemia,
  - Hemophilia,
  - Immune thrombocytopenic purpura,
  - Myelodysplastic syndrome,
  - Sickle-cell disease (excluding sickle-cell trait), and
  - Chronic venous thromboembolic disorder;
- HIV/AIDS;
- Chronic lung disorders:
  - Asthma,
  - Chronic bronchitis,
  - Cystic Fibrosis,
  - Emphysema,
  - Pulmonary fibrosis,
  - Pulmonary hypertension, and
  - Chronic Obstructive Pulmonary Disease (COPD);

- Chronic and disabling mental health conditions:
  - Bipolar disorders,
  - Major depressive disorders,
  - Paranoid disorder,
  - Schizophrenia,
  - Schizoaffective disorder,
  - Post-traumatic stress disorder (PTSD),
  - Eating Disorders, and
  - Anxiety disorders;
- Neurologic disorders:
  - Amyotrophic lateral sclerosis (ALS),
  - Cerebral Palsy
  - Epilepsy,
  - Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia),
  - Huntington's disease,
  - Multiple sclerosis,
  - Parkinson's disease,
  - Polyneuropathy,
  - Fibromyalgia,
  - Chronic fatigue syndrome,
  - Spinal cord injuries,
  - Spinal stenosis,
  - Stroke-related neurologic deficit; and
  - Traumatic brain injury
- Stroke;
- Post-organ transplantation care;
- Immunodeficiency and Immunosuppressive disorders;
- Conditions that may cause cognitive impairment:
  - Alzheimer's disease,
  - Intellectual and developmental disabilities,
  - Traumatic brain injuries,
  - Disabling mental illness associated with cognitive impairment, and
  - Mild cognitive impairment;
- Conditions that may cause similar functional challenges and require similar services:

  - Spinal cord injuries,
  - Paralysis,
  - Limb loss,
  - Stroke, and
  - Arthritis;
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell;
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
- Other
  - Chronic Hypertension
  - Osteoporosis
  - Chronic back pain

The plan will need to get verification of the chronic condition through our medical claims history or from our healthcare provider.

To determine if our plan offers SSBCI benefits, refer to the Medical Benefits Chart located at the front of this document. SSBCI benefits are located under the additional benefits section.

For further information contact customer service on the back of our member ID card.

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

SECTION 3 Services that aren't covered by our plan (exclusions)

This section tells you what services are “excluded” from Medicare coverage and therefore, aren't covered by this plan.

The chart below lists services and items that either aren't 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 get the excluded services at an emergency facility, the excluded services are still not covered and our plan won't 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 made to not cover a medical service, go to Chapter 7, Section 5.3.)

Review the Medical 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		Available for people with chronic low back pain, unless specified otherwise in the Medical 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 Medical Benefits Chart at the front of this document
Ambulette services		Unless specified otherwise in the Medical Benefits Chart at the front of this document
Bathroom assistance equipment		Unless specified otherwise in the Medical 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	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Charges in excess of the maximum allowable amount		Unless specified otherwise in the Medical 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
Custodial care is personal care that doesn't 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 Medical 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 Go to Chapter 3, Section 5 for more information on clinical research studies
Eye refractions		Unless specified otherwise in the Medical Benefits Chart at the front of this document

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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 Medical Benefits Chart at the front of this document
Full-time nursing care in your home		Unless specified otherwise in the Medical Benefits Chart at the front of this document
Homemaker services include basic household help, including light housekeeping or light meal preparation		Unless specified otherwise in the Medical Benefits Chart at the front of this document
Hospice services in a Medicare-participating hospice are not paid for by this PPO, but reimbursed directly by Original Medicare when you're enrolled in a Medicare-certified Hospice		Unless specified otherwise in the Medical Benefits Chart at the front of this document
Meals delivered to your home		Unless specified otherwise in the Medical Benefits Chart at the front of this document
Naturopath services (uses natural or alternative treatments)		Unless specified otherwise in the Medical 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 Medical Benefits Chart at the front of this document

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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 get from a pharmacy under the medical, Part B coverage See the Medical 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 Medical 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	
Routine chiropractic care		Only manual manipulation of the spine to correct a subluxation is covered, unless specified otherwise in the Medical Benefits Chart at the front of this document
Routine dental care, such as cleanings, fillings or dentures		Unless specified otherwise in the Medical Benefits Chart at the front of this document If our benefit chart reflects coverage for crowns or implants, refer to the additional information located at the end of this chapter.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids		One pair of eyeglasses with standard frames (or one set of contact lenses) is covered after each cataract surgery that implants an intraocular lens, unless specified otherwise in the Medical Benefits Chart at the front of this document. If our plan covers eye wear, safety eye wear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered.
Routine foot care		Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes, unless specified otherwise in the Medical Benefits Chart at the front of this document
Routine hearing exams, hearing aids, or exams to fit hearing aids		Unless specified otherwise in the Medical 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 Medical 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 not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services or supplies primarily for educational, vocational or training purposes		Unless specified otherwise in the Medical Benefits Chart at the front of this document
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'll 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 for covered medical services

SECTION 1 Situations when you should ask us to pay our share for your covered services

Sometimes when you get medical care, you may need to pay the full cost. Other times, you may pay more than you expected under the coverage rules of our plan. Or you may get a bill from a provider. In these cases, you can ask your plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services covered by your plan. There may be deadlines that you must meet to get paid back. Go to 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 got or for more than our share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll 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.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have got:

1. When you got medical care from a provider who isn't in our plan's network

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

When you got care from a provider who isn't part of our network, you're 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 our plan for our share of the cost.

- Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get 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 made.
- You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
  - If the provider is owed anything, we'll pay the provider directly.
  - If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.
- 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 can't pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you'll be responsible for the full cost of the services you got.

2. When an in-network provider sends you a bill you think you shouldn't pay

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

In-network providers should always bill our plan directly and ask you only for our 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 don't 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 you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to an in-network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

Sometimes a person’s enrollment in our 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 covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills, for us to handle the reimbursement.

When you send us a request for payment, we’ll review your request and decide whether the service or drug should be covered. This is called making a coverage decision. If we decide it should be covered, we’ll pay our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 7 has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or pay a bill you got

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

You can ask 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 got the service or item. To make sure you're 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 got the service or item.

SECTION 3 We'll consider your request for payment and say yes or no

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

- If we decide the medical care is covered and you followed all the rules, we'll 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'll mail your reimbursement of our share of the cost to you. **If you haven't paid for the service yet, call 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'll process covered services according to your plan benefits. Any payment will be made to the provider.**
- If we decide the medical care is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 If we tell you that we won't pay for all or part of the medical care, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're 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.

CHAPTER 6:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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)

Our 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 our plan may meet these accessibility requirements include, but aren't limited to provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you materials in alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's 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 our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost sharing.

If you have any trouble getting information from your plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can 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 you get timely access to covered services

You have the right to choose a provider in our 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. Refer to the Medical Benefits Chart for more information.

You have the right to get appointments and covered services from our 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 aren't 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're 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 don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We're required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of your plan through Medicare, we're 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's been shared with others

You have the right to look at your medical records held at our plan, and to get a copy of your records. We're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services.

Protecting your personal health information is important. Each 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

Would you like to go paperless and read this online or on your mobile app? Go to **www.anthem.com/ca/calpers** and sign up to get these notices by email

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 ID 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 MEDICAL, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. 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 PHI with technology to support and enable services provided to you.
- 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.
- Responding to the Secretary of Human and Health Services for HIPAA rules compliance and enforcement purposes.

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 collect, infer, receive and/or maintain 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 ID 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 information 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. One example is with Substance Use Disorder (SUD) Information we may receive from Providers or programs regulated by federal law (42 CFR Part 2). All disclosures of such SUD information must comply with applicable Federal and State privacy laws, including 42 CFR Part 2. We are allowed to Use and Disclose SUD information for certain Treatment, Payment, and Health Care Operations activities. You have the right to consent to the disclosure of SUD information in certain circumstances. You can revoke this consent in writing at any time.

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 ID 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 ID 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 2025. 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 ID 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. 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: **http://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/whcra**.

It's important we treat you fairly

We follow federal civil rights laws in our health programs and activities. We don't discriminate, exclude people, or treat them differently based on race, color, national origin, sex, age or disability. If you have disabilities, we offer free aids and services. If your main language isn't English, we offer help for free through interpreters and other written languages. Call the Member Services number on your ID card for help (TTY/TDD: **711**).

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint through one of these ways:

Write to Compliance Coordinator, **P.O. Box 27401, Mail Drop VA2002-N160 Richmond, VA 23279**.

File a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights at **200 Independence Avenue, SW; Room 509F, HHH Building; Washington, D.C. 20201**.

Call **1-800-368-1019** (TDD: **1-800-537-7697**).

Go online at **https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf** and fill out a complaint form at **https://www.hhs.gov/ocr/complaints/index.html**.

Get help in your language

One more right that you have is to get this information in your language for free. If you'd like extra help to understand this in another language, call the Member Services number on your ID card (TTY/TDD: **711**).

Aside from helping you understand your privacy rights in another language, we also offer this notice in a different format for members with visual impairments. If you need a different format, please call the Member Services number on your ID card.

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

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

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

- **Information about our plan.** This includes, for example, information about our 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 isn't 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 You have the right to know your treatment options and participate in decisions about your 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. 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's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance in these situations are called **"advance directives."** Documents like **"living will"** and **"power of attorney for health care"** are examples of advance directives.

How to set an "advance directive" to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, from a social worker or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** 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're going to be hospitalized, and you 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 didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

Filling out an advance directive is your choice (including whether you want to sign one if you're in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you signed an advance directive.

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the appropriate state-specific agency. For contact information, refer to the state-specific agency listing located in Chapter 11.

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

If you have any problems, concerns, or complaints and need to ask for 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're required to treat you fairly**.

Section 1.7 If you believe you're being treated unfairly, or your rights aren't being respected

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

If you believe you've been treated unfairly or your rights haven't been respected, and it's not about discrimination, you can get help dealing with the problem you're having from these places:

- Call **Member Services**.
- Call your local **SHIP**. For contact information, refer to the state-specific agency listing located in Chapter 11.
- **Call Medicare** at **1-800-MEDICARE (1-800-633-4227)**, (TTY users call **1-877-486-2048**).

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- Call **Member Services**.
- Call your local **SHIP**. For contact information, refer to the state-specific agency listing located in Chapter 11.
- Call **Medicare**.
    - Visit **www.Medicare.gov** to read the publication *Medicare Rights & Protections* available at **www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf**.

- Call **1-800-MEDICARE** (**1-800-633-4227**); (TTY **1-877-486-2048**)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, 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's covered and the rules you need to follow to get covered services.
  - The Medical Benefits Chart located at the front of this document and Chapters 3 and 4 give details about our medical services.
- **If you have any other health coverage in addition to our plan, or separate drug coverage, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in your plan.** Show our ID 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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate**. We expect 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're responsible for these payments:
  - Your group sponsor must pay our 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 stay a member of the plan.
  - For most of your medical services covered by our 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 our membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
  - If you move, tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

If you have a problem or complaint (coverage decisions, appeals, complaints)

SECTION 1 What to do if you have a problem or concern

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. Call Member Services. We'll 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 2 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 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 information in this chapter will help you identify the right process to use and what to do.

Section 1.1 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. To make things easier, this chapter uses more familiar words in place of some legal terms:

However, it's sometimes important 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 these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services for help. In some situations you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

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're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. For contact information, refer to the state-specific agency listing located in Chapter 11.

Medicare

You can also contact Medicare for help:

- Call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.
- Visit **www.Medicare.gov**.

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to, **Section 4, A guide to coverage decisions and appeals.**

No.

Go to, **Section 9, 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 coverage decisions and appeals

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items, and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B 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 before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got 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'll cover a particular medical service or refuses to provide medical care you think you need. 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'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered 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 you get a benefit, and you aren't satisfied, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for 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 properly followed the rules. When we complete 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'll 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 not connected to us.

- You don't 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 don't fully agree with your Level 1 appeal.
- Go to Section 5.4 of this chapter for more information about Level 2 appeals for medical care.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 Get help 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:

- **Call Member Services**.
- **Get free help from** your State Health Insurance Assistance Program. For contact information, 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 need to be appointed as your representative. Call Member Services and ask for the "Appointment of Representative" form. (The form is also available at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**.)

  - For medical care or Part B drugs, your doctor can ask for 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.** 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 at **www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request form or an equivalent written notice from a representative, we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll 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 can contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 3 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal"
- **Section 6:** "How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon"
- **Section 7:** "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 information applies to you, call Member Services. You can also get help or information from your State Health Insurance Assistance Program.

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

Section 5.1 What to do if you have problems getting coverage for medical care or want us to pay you back for our share of the cost of your care

Your benefits for medical care are described in the Medical Benefits Chart located at the front of this document and in Chapter 4 of this document. In some cases, different rules apply to a request for a Part

B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't 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 won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask your plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're being told that coverage for certain medical care you've 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, go to Section 6 and 7. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

LEGAL TERMS	A coverage decision that involves your medical care 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 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items or services, 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. To get a fast coverage decision, you must meet 2 requirements:

- You may only ask for coverage for medical care items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function*.
- **If your doctor tells us that your health requires a "fast coverage decision," we'll 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'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we'll 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 asked for.

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'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a **Part B drug**, we'll give you an answer **within 72 hours** after we get 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 calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a "fast complaint." We'll give you an answer to your complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 9 for information about complaints.)

For fast coverage decisions we use an expedited timeframe

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll 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 calendar more days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a "fast complaint". (Go to Section 9 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for**, we'll 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're going on to Level 1 of the appeals process.

Section 5.3 How to make a Level 1 appeal

LEGAL TERMS	An appeal to our 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 calendar days or 7 calendar 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.

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

- **If you're asking for a standard appeal, submit your standard appeal** in writing. You may also ask for an appeal by calling us Chapter 2 has contact information.
- **If you're 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 65 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 asking for 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 the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed, and may contact you or your doctor.

Deadlines for a "fast appeal"

- For fast appeals we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.

- 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'll tell you in writing. We can't take extra time if your request is for a Part B drug.
- If we don't give you an answer within 72 hours, or by the end of the extended time period if we took extra days, we're required to automatically send your request 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 asked for**, we'll 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 gets your appeal.

Deadlines for a "standard appeal"

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll 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'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a "fast complaint." When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 9.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll 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 asked for**, 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 Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for Level 2.

Section 5.4 The Level 2 appeal process

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

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and it isn't 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'll 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 about your appeal.

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

- For the "fast appeal" the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

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

- For the "standard appeal" if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you it's decision in writing and explain the reasons for it.

- **If the independent 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 get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we receive the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug under dispute within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent 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 shouldn't be approved. (This is called **"upholding the decision"** or **"turning down your appeal"**). In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your 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.
- Tells 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 3 additional levels in the appeals process after Level 2 (for a total of 5 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 explains Levels 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 5 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this coverage decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using our coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll 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 won't send payment. Instead, we'll send you a letter that says we won't 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 don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't 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 asked for to you or the provider within 60 calendar days.

SECTION 6 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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're 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 tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll 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 don't get the notice from someone at the hospital (for example, a caseworker or nurse) ask any hospital employee for it. If you need help, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**), (TTY users call **1-877-486-2048**).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
    - Your right to get 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're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time.
2. **You'll be asked to sign the written notice to show that you got 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 got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.

3. **Keep your copy of the notice** so you'll 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 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
    - To look at a copy of this notice in advance, call Member Services. Or you can call Medicare at **1-800-MEDICARE** (**1-800-633-4227**), TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Section 6.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, 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 paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't 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 got (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 can 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 don't meet this deadline, contact us. If 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 get after your planned discharge date.

- Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted we'll 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's 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**), (TTY users call **1-877-486-2048**.) Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

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 can if you want.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll 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 independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll 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 independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said no to your appeal, and you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you're going to "Level 2" of the appeals process.

Section 6.3 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 it's 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 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 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 it's decision.

If the independent review organization says yes

- **Your plan must reimburse you** for our share of the costs of hospital care you got 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's medically necessary**.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the independent 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 want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2, for a total of 5 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 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're 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's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care*.

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

Section 7.1 We'll tell you in advance when your coverage will be ending

LEGAL TERMS	**"Notice of Medicare Non-Coverage."** It tells you how you can ask for a **"fast-track appeal."** Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care. (explains how you can ask for a fast-track appeal.)

1. **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
    - The date when we'll stop covering the care for you.
    - How to ask for a "fast track appeal" to ask for us to keep covering your care for a longer period of time.
2. **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got it.**
    - Signing the notice shows *only* that you got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 7.2 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'll 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, call Member Services. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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 aren't 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 got (*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, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 11.

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

LEGAL TERMS	**"Detailed Explanation of Non-Coverage."** Notice that gives 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information your plan gives them.
- By the end of the day the reviewers tell your plan of your appeal, you'll 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 it's 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's medically necessary**.

- You'll 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 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, **you'll 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 7.3 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 calendar 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 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 the information related to your appeal.

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

What happens if the independent review organization says yes?

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

What happens if the independent 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 want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 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 8 Taking your appeal to Level 3, 4 and 5

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's 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's 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 we get the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we'll 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 the decision that turns down your appeal, the appeals process is over.

- If you don't 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'll 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 getting the Council's decision.
  - If we decide to appeal the decision, we'll 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 don't 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 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 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 got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
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're being encouraged to leave our 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 our plan? ○ Examples include waiting too long on the phone, in the waiting room, or in the exam room, or getting a prescription.
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 about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't 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 said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't 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 called "**filing a grievance**." • "**Using the process for complaints**" is called "**using the process for filing a grievance**." • A "**fast complaint**" is called an "**expedited grievance**."

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

- **Calling Member Services is usually the first step**. If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call, or you called and weren't satisfied, you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll 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'll 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'll tell you in writing.
- **If you're making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we'll automatically give you a "fast complaint."** If you have a "fast complaint," it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 9.3 You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 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 9.4 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/my/medicare-complaint**. You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

CHAPTER 8:

Ending your membership in our plan

SECTION 1 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 decide you want to leave. Section 2 and 3 give information on ending our membership voluntarily.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and you'll 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 Open Enrollment Period for Individual (non-group) plans

You can end your membership in our plan during the Open Enrollment Period each year. During this time, review your health and drug coverage and decide on coverage for the upcoming year.

- **The Open 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 drug coverage.
  - Original Medicare *with* a separate Individual (non-group) Medicare drug plan.
  - Original Medicare without a separate Individual (non-group) Medicare 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, call 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 can make *one* change to your health coverage during the **Individual (non-group) Medicare Advantage Open Enrollment Period each year**.

- **The Individual (non-group) Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Individual (non-group) Medicare Advantage Open Enrollment Period** you can:
    - Switch to another Medicare Advantage Plan with or without drug coverage.
    - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same 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, call 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 drug plan, your membership in the drug plan will start 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.

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 our plan, call Medicare, or visit the **www.Medicare.gov**
    - Usually, when you move.
    - If you have Medicaid.
    - If we violate our contract with you.

- If you're getting 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 isn't available in all states. If you would like to know if PACE is available in your state, call Member Services.

- **Enrollment time periods vary** depending on your situation.
- **To find out if you're eligible for a Special Enrollment Period**, call **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, TTY users call **1-877-486-2048**. If you're eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and drug coverage. You can choose:
  - An Individual (non-group) Medicare health plan. You can choose a plan with or without drug coverage.
  - Original Medicare *with* a separate Individual (non-group) Medicare drug plan.
  - Original Medicare *without* a separate Medicare 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, call your group sponsor.**
- **Your membership will end** on the first of the month after we get your request to change plans or the date you request we terminate coverage on this plan, whichever is later.

Section 2.4 Get more information about when you can end your membership

If you have 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 2026*** handbook.
- Contact **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

SECTION 3 How to 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, call your group sponsor.

The table below explains how you should end your membership in our plan.

To switch from our plan to:	Here's what to do:
An Individual (non-group) Medicare health plan.	• Enroll in the new Medicare health plan between October 15 and December 7. • You'll automatically be disenrolled from your group-sponsored plan when your new drug plan's coverage starts.
Original Medicare with a separate Individual (non-group) Medicare drug plan.	• Enroll in the new Medicare drug plan between October 15 and December 7. • You'll automatically be disenrolled from your group-sponsored plan when your new drug plan's coverage starts.
Original Medicare without a separate Medicare drug plan.	• **Send us a written request to disenroll**. Call Member Services if you need more information on how to do this. • You can also call Medicare at **1-800-MEDICARE (1-800-633-4227)**, and ask to be disenrolled. TTY users call **1-877-486-2048**. • You will be disenrolled from your group-sponsored plan when your coverage in Original Medicare starts.

Note: If you also have creditable drug coverage (e.g., a separate Medicare drug plan) 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 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 starts, you must continue to get your medical items, services through our plan.

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

SECTION 5 We must end our plan membership in certain situations

We must end our membership in our 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're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services to find out if the place you're moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you're no longer a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan. We can't make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We can't make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your ID card to get medical care. We can't 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're 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.

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

Section 5.1 We can't 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're 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**).

Section 5.2 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, (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 aren't included or explained in this document.

SECTION 2 Notice about nondiscrimination

Discrimination is against the law. That's why we comply with applicable Federal civil rights laws and do not discriminate, exclude people or treat them differently on the basis of race, color, national origin, age, disability, or sex.

For people with disabilities, we provide free aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

For people whose primary language is not English, we offer free language assistance services, which may include:

- Qualified interpreters
- Information written in other languages

If you need these services, call the phone number on your member ID card for help.

If you think we failed to offer these services or discriminated based on race, color, national origin, age, disability, or sex, you can file a complaint, also known as a grievance. You can file a complaint with our Compliance Coordinator in writing to:

Compliance Coordinator
4361 Irwin Simpson Rd
Mailstop: OH0205-A537
Mason, Ohio 45040-9498

You can also file a complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019 (TTY: **1-800-537-7697**)

Complaint forms are available at **www.HHS.gov/ocr/index.html**.

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.

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, certain services provided by out-of-network providers at in-network facilities, and out-of-network air ambulance 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

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 don't accept assignment but who are subject to the limiting amount;
4. The provider's actual charge when the provider does not accept assignment and isn't subject to the limiting amount; or
5. The provider's actual charge for non-Medicare covered benefits, our 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 doesn't exceed 24 hours.

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 got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

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 don't 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 haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There's 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 people who have specific severe and chronic diseases.

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'll 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. Go to Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount. Refer to the Medical Benefit 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 get. It also includes complaints if our plan doesn't 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 3 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 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 don't 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 people 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 person's eligibility.

Dual Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by our 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're 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 doesn't involve coverage or payment disputes.

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

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. Our plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you're still a member of our plan. You can still get 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'll pay for covered Part A and Part B services received from in-network (preferred) providers. After you have reached this limit, you won't 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 our 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 our 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're 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 (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term care facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

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 Medical 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 i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a 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 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or get 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 a person 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 the services that are covered by Medicare Part A and Part B. The term Medicare-Covered Services doesn't 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 our 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.

Open Enrollment Period — A set period of time determined by the client, a retiree is eligible to elect to enroll or make changes to their current enrollment in a Medicare Advantage, Medicare Advantage/Prescription Drug or Prescription Drug plan offered by their former employer. If the retiree does not enroll in a Medicare Advantage plan at that time, they will remain in Original Medicare or their current plan. In some instances, a special enrollment period may be available to individuals to elect an Individual plan.

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 2 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 doesn't have a contract with our plan to coordinate or provide covered services to members of your plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to 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 get both their Medicare and Medicaid benefits through our plan. If you would like to know if PACE is available in your state, call Member Services.

Part C – Go to 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.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

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 based on specific criteria. In the network portion of a PPO, some in-network medical services are covered only if our doctor or other in-network provider gets "prior authorization" from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart located at the front of this document.

Prosthetics and Orthotics – Medical devices including, but aren't 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.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services, when one is required by our plan. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), 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. Our plan may disenroll you if you permanently move out of our 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 live 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 aren't the same as Social Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

CHAPTER 11:

State organization contact information

SECTION 1 State Health Insurance Assistance Program (SHIP)

The following state agency information was updated on 08/01/2025. For more recent information or other questions, call Member Services.

Alabama

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

Alaska

Alaska State Health Insurance Assistance Program (SHIP)
1835 Bragaw Street, Suite 350
Anchorage, AK 99508
1-800-478-6065, TTY: **1-800-770-8973**
https://dhss.alaska.gov/health/dsds/Pages/medicare/default.aspx

Arizona

Arizona State Health Insurance Assistance Program (SHIP)
1789 West Jefferson, Site Code MD6288
Phoenix, AZ 85007
1-800-432-4040, TTY: **711**
https://des.az.gov/services/aging-and-adult/state-health-insurance-assistance-program-ship

Arkansas

Arkansas Senior Health Insurance Information Program (SHIIP)
#1 Commerce Way, Suite 102
Little Rock, AR 72202
1-800-224-6330, TTY: **711**
https://insurance.arkansas.gov/pages/consumer-services/senior-health/

California

California Health Insurance Counseling and Advocacy Program (HICAP)
1300 National Drive, Suite 200
Sacramento, CA 95833
1-800-434-0222, TTY: **711**
https://www.aging.ca.gov/hicap/

Colorado

Colorado Senior Health Insurance Assistance Program (SHIP)
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

Connecticuts program for Health insurance assistance, Outreach, Information and referral, Counseling, Eligibility Screening (CHOICES)
55 Farmington Avenue, 12th Floor
Hartford, CT 06105
1-800-994-9422, TTY: **1-860-247-0775**
http://www.ct.gov/agingservices/cwp

Delaware

Delaware Medicare Assistance Bureau (DMAB)
1351 West North Street Suite 101
Dover, DE 19904
1-800-336-9500, TTY: **711**
https://insurance.delaware.gov/

District Of Columbia

DC State Health Insurance Assistance Program (SHIP)
250 E. St. SW
Washington, DC 20024
1-202-727-8370, TTY: **711**
https://dcoa.dc.gov/service/health-insurance-counseling

Florida

Florida Serving Health Insurance Needs of Elders (SHINE)
4040 Esplanade Way, Suite 280-S
Tallahassee, FL 32399-7000
1-800-963-5337, TTY: **1-800-955-8770**
http://www.floridashine.org/

Georgia

Georgia SHIP
2 Peachtree Street NW, 33rd Floor
Atlanta, GA 30303
1-866-552-4464, TTY:
https://aging.georgia.gov/georgia-ship

Hawaii

Hawaii State Health Insurance Assistance Program (SHIP)
250 South Hotel Street, Suite 406
Honolulu, HI 96813-2831
1-888-875-9229, TTY: **1-866-810-4379**
http://www.hawaiiship.org/

Idaho

Idaho Senior Health Insurance Benefits Advisors Program (SHIBA)
700 West State Street, P.O. Box 83720
Boise, ID 83720-0043
1-800-247-4422, TTY: **711**
http://www.shiba.idaho.gov

Illinois

Illinois Senior Health Insurance Program (SHIP)
1 Natural Resources Way, Suite 100
Springfield, IL 62702-1271
1-800-252-8966, TTY: **711**
https://ilaging.illinois.gov/ship/aboutship.html

Indiana

State Health Insurance Assistance Program (SHIP)
311 W. Washington Street, 2nd Floor
Indianapolis, IN 46204-2787
1-800-452-4800, TTY: **1-866-846-0139**
http://www.medicare.in.gov

Iowa

Iowa Senior Health Insurance Information Program (SHIIP)
601 Locust, 4th Floor
Des Moines, IA 50309-3738
1-800-351-4664, TTY: **1-800-735-2942**
https://shiip.iowa.gov/

Kansas

Senior Health Insurance Counseling for Kansas (SHICK)
503 S. Kansas Ave.
Topeka, KS 66603-3404
1-800-860-5260, TTY: **711**
https://kdads.ks.gov/kdads-commissions/long-term-services-supports/aging-services/medicare-programs/shick

Kentucky

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

Louisiana

Senior Health Insurance Information Program (SHIIP)
P.O. Box 94214
Baton Rouge, LA 70804-9214
1-800-259-5300, TTY: **711**
http://www.ldi.la.gov/consumers/senior-health-shiip

Maine

Maine State Health Insurance Assistance Program (SHIP)
41 Anthony Ave.
Augusta, ME 04333
1-800-262-2232, TTY: **711**
https://www.maine.gov/dhhs/oads/get-support/older-adults-disabilities/older-adult-services/ship-medicare-assistance

Maryland

Maryland Department of Aging -Senior Health Insurance Assistance Program (SHIP)
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

Massachusetts Serving the Health Insurance Needs of Everyone (SHINE)
One Ashburton Place, 5th floor
Boston, MA 02108
1-617-727-7750, TTY: **1-877-610-0241**
https://www.mass.gov/orgs/executive-office-of-elder-affairs

Michigan

Michigan Medicare/Medicaid Assistance Program (MMAP), Inc.
6105 W Joe Hwy, #204
Lansing, MI 48917
1-800-803-7174, TTY: **1-888-263-5897**
http://mmapinc.org/

Minnesota

Minnesota State Health Insurance Assistance Program/Senior LinkAge Line
540 Cedar Street, P.O. Box 64976
St. Paul, MN 55164
1-800-333-2433, TTY: **1-800-627-3529**
http://www.mnaging.org/Advisor/SLL/SLL_SHIP.aspx

Mississippi

Mississippi State Health Insurance Assistance Program (SHIP)
200 South Lamar St
Jackson, MS 39201
1-800-948-3090, TTY:
http://www.mdhs.ms.gov/

Missouri

Missouri State Health Insurance Assistance Program (SHIP)
601 W Nifong Blvd, Suite 3A
Columbia, MO 65203
1-800-390-3330, TTY: **711**
http://missouriclaim.org/

Montana

Montana State Health Insurance Assistance Program (SHIP)
1100 N Last Chance Gulch, 4th Floor
Helena, MT 59601
1-800-551-3191, TTY: **711**
https://dphhs.mt.gov/sltc/aging/ship

Nebraska

Nebraska State Health Insurance Assistance Program (SHIP)
PO Box 95087,
Lincoln, NE 68509-5087
1-800-234-7119, TTY: **711**
https://doi.nebraska.gov/consumer/senior-health

Nevada

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

New Hampshire

New Hampshire ServiceLink Resource Centers
129 Pleasant Street
Concord, NH 03301
1-866-634-9412, TTY: **711**
http://www.servicelink.nh.gov

New Jersey

New Jersey State Health Insurance Assistance Program (SHIP)
P.O. Box 807
Trenton, NJ 08625-0807
1-800-792-8820, TTY: **711**
http://www.state.nj.us/humanservices/doas/services/ship/index.html

New Mexico

New Mexico ADRC State Health Insurance Assistance Program (SHIP)
2550 Cerrillos Road
Santa Fe, NM 87505
1-800-432-2080, TTY: **1-505-476-4937**
http://www.nmaging.state.nm.us/

New York

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

North Carolina

North Carolina Seniors' Health Insurance Information Program (SHIIP)
1201 Mail Service Center
Raleigh, NC 27699-1201
1-855-408-1212, TTY: **711**
https://www.ncdoi.gov/consumers/medicare-and-seniors-health-insurance-information-program-shiip/contact-seniors-health-insurance-information-program-shiip

North Dakota

North Dakota Senior Health Insurance Counseling (SHIC)
600 E Boulevard, Department 401
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 (OSHIIP)
50 W. Town Street, Suite 300
Columbus, OH 43215
1-800-686-1578, TTY: **1-614-644-3745**
https://insurance.ohio.gov/about-us/divisions/oshiip

Oklahoma

Oklahoma Medicare Assistance Program (MAP)
400 NE 50th Street
Oklahoma City, OK 73105
1-800-763-2828, TTY: **711**
http://www.map.oid.ok.gov

Oregon

Oregon Senior Health Insurance Benefits Assistance (SHIBA)
350 Winter Street NE, Room 330
Salem, OR 97309-0405
1-800-722-4134, TTY: **711**
http://www.oregon.gov/DCBS/SHIBA/pages/index.aspx

Pennsylvania

Pennsylvania Medicare Education and 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 Assistance Program (SHIP)
25 Howard Ave
Cranston, RI 02920
1-401-462-3000, TTY: **1-401-462-0740**
https://oha.ri.gov/what-we-do/access/health-insurance-coaching/medicare-counseling

South Carolina

South Carolina Senior Health Insurance Assistance Program (SHIP)
1301 Gervais Street, Suite 350
Columbia, SC 29201
1-800-868-9095, TTY: **711**
https://aging.sc.gov/programs-initiatives/medicare-and-medicare-fraud

South Dakota

South Dakota Senior Health Information and Insurance Education (SHIINE)
2200 N Maple Ave Unit 104
Rapid City, SD 57701
1-800-536-8197, TTY: **711**
http://www.shiine.net/

Tennessee

Tennessee State Health Insurance Assistance Program (SHIP)
502 Deaderick St., 9th Floor
Nashville, TN 37243
1-877-801-0044, TTY: **1-800-848-0299**
http://tnmedicarehelp.com/

Texas

Texas Department of Aging and Disability Services (HICAP)
701 West 51st Street, MC: W275
Austin, TX 78751-3146
1-800-252-9240, TTY: **1-800-735-2989**
https://www.hhs.texas.gov/services/health/medicare

Utah

Utah Senior Health Insurance Information Program (SHIIP)
288 N. 1460 West
Salt Lake City, UT 84116
1-800-541-7735, TTY: **711**
https://daas.utah.gov/seniors/

Vermont

Vermont State Health Insurance Assistance Program
476 Main Street, Suite #3
Winooski, VT 05404
1-800-642-5119, TTY: **711**
https://www.vermont4a.org/medicare-information

Virginia

VA Insurance Counseling & Assistance Program (VICAP)
1610 Forest Avenue, Suite 100
Henrico, VA 23229
1-804-662-9333, TTY: **711**
https://www.vda.virginia.gov/vicap.htm

Washington

Washington Statewide Health Insurance Benefits Advisors (SHIBA)
5000 Capitol Boulevard
Tumwater, WA 98504-0256
1-800-562-6900, TTY: **1-360-586-0241**
https://www.insurance.wa.gov/statewide-health-insurance-benefits-advisors-shiba

West Virginia

West Virginia State Health Insurance Assistance Program (WV SHIP)
1900 Kanawha Blvd. East, 3rd Floor Town Center Mall
Charleston, WV 25305
1-877-987-4463, TTY: **711**
http://www.wvship.org/

Wisconsin

Wisconsin State Health Insurance Assistance Program (Wisconsin SHIP)
1 West Wilson Street, P.O. Box 7851
Madison, WI 53703
1-800-242-1060, TTY: **711**
https://www.dhs.wisconsin.gov/benefit-specialists/medicare-counseling.htm

Wyoming

Wyoming State Health Insurance Information Program (WSHIIP)
106 West Adams Ave
Riverton, WY 82501
1-800-856-4398, TTY: **711**
http://www.wyomingseniors.com/

SECTION 2 Quality Improvement Organization (QIO)

The following state agency information was updated on 08/01/2025. For more recent information or other questions, call Member Services.

Alabama

KEPRO - Alabama's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Alaska

KEPRO - Alaska's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Arizona

Livanta - Arizona's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Arkansas

KEPRO - Arkansas' Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

California

Livanta - California's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Colorado

KEPRO - Colorado's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Connecticut

KEPRO - Connecticut's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Delaware

Livanta - Delaware's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

District Of Columbia

Livanta - District of Columbia's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Florida

KEPRO - Florida's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Georgia

KEPRO - Georgia's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Hawaii

Livanta - Hawaii's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Idaho

KEPRO - Idaho's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Illinois

Livanta - Illinois's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Indiana

Livanta - Indiana's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Iowa

Livanta BFCC - Iowa's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Kansas

Livanta BFCC - Kansas' Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Kentucky

KEPRO - Kentucky's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Louisiana

KEPRO - Louisiana's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Maine

KEPRO - Maine's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Maryland

Livanta - Maryland's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Massachusetts

KEPRO - Massachusetts' Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Michigan

Livanta - Michigan's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Minnesota

Livanta - Minnesota's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Mississippi

KEPRO - Mississippi's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Missouri

Livanta - Missouri's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Montana

KEPRO - Montana's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Nebraska

Livanta - Nebraska's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-755-5580, TTY: **1-888-985-9295**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Nevada

Livanta- Nevada's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-877-588-1123, TTY: **1-855-887-6668**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

New Hampshire

KEPRO - New Hampshire's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

New Jersey

Livanta - New Jersey's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

New Mexico

KEPRO - New Mexico's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

New York

Livanta - New York's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-866-815-5440, TTY: **1-866-868-2289**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

North Carolina

KEPRO - North Carolina's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

North Dakota

KEPRO - North Dakota's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Ohio

Livanta - Ohio's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Oklahoma

KEPRO - Oklahoma's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Oregon

KEPRO - Oregon's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Pennsylvania

Livanta - Pennsylvania's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Rhode Island

KEPRO - Rhode Island's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

South Carolina

KEPRO - South Carolina's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

South Dakota

KEPRO - South Dakota's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Tennessee

KEPRO - Tennessee's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0751, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Texas

KEPRO - Texas's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-315-0636, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Utah

KEPRO - Utah's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Vermont

KEPRO - Vermont's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-319-8452, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

Virginia

Livanta - Virginia's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Washington

KEPRO - Washington's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-305-6759, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

West Virginia

Livanta - West Virginia's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-396-4646, TTY: **1-888-985-2660**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Wisconsin

Livanta - Wisconsin's Quality Improvement Organization
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701-1105
1-888-524-9900, TTY: **1-888-985-8775**
9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
https://www.livantaqio.com

Wyoming

KEPRO - Wyoming's Quality Improvement Organization
5201 W. Kennedy Blvd., Suite 900
Tampa, FL 33609
1-888-317-0891, TTY: **711**
9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, weekends and holidays
https://www.keproqio.com/

SECTION 3 State Medicaid Offices

The following state agency information was updated on 08/01/2025. For more recent information or other questions, call Member Services.

Alabama

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

Alaska

Alaska Medicaid
3601 C Street
Suite 902
Anchorage, AK 99503
1-800-780-9972, TTY: **711**
8 a.m. - 5 p.m. AKT, Monday - Friday
https://dhss.alaska.gov/health/dhcs/Pages/medicaid_medicare/default.aspx

Arizona

Arizona Health Care Cost Containment System (AHCCCS)
801 E Jefferson St
Phoenix, AZ 85034
1-602-417-4000, TTY: **1-800-842-6520**
8 a.m. - 5 p.m. MT, Monday - Friday
https://www.azahcccs.gov/

Arkansas

Arkansas Medicaid
P.O. Box 1437
Slot S401
Little Rock, AR 72203-1437
1-800-482-5431, TTY: **711**
8 a.m. - 4:30 p.m. CT, Monday - Friday
https://humanservices.arkansas.gov/divisions-shared-services/medical-services/

California

California Medi-Cal (Medicaid)
P.O. Box 997413
MS 4400
Sacramento, CA 95899-7413
1-800-541-5555, TTY: **1-800-430-7077**
8 a.m. - 5 p.m. PT, Monday - Friday
https://www.dhcs.ca.gov/services/medi-cal/Pages/default.aspx

Colorado

Health First Colorado (Colorado's Medicaid Program)
1570 Grant St
Denver, CO 80203-1818
1-800-221-3943, TTY: **711**
8 a.m. - 4:30 p.m. MT, Monday - Friday; closed on holidays
https://www.healthfirstcolorado.com/

Connecticut

HUSKY Health For Connecticut Children & Adults (Medicaid)
P.O. Box 5005
Wallingford, CT 06492
1-855-805-4325, TTY: **1-855-789-2428**
8:00 a.m. - 4 p.m. Monday - Friday
http://ct.gov/hh/site/default.asp

Delaware

Delaware Medicaid
1901 N DuPont Highway
New Castle, DE 19720
1-866-843-7212, TTY: **711**
8 a.m. - 4:30 p.m. ET, Monday - Friday
http://www.dhss.delaware.gov/dss/medicaid.html

District Of Columbia

District of Columbia Medicaid Program
441 4th Street NW
#900s
Washington, DC 20001
1-202-442-5988, TTY: **711**
8:15 a.m. - 4:45 p.m. ET, Monday - Friday
https://dc.gov/service/medicaid

Florida

Agency for Healthcare Administration
2727 Mahan Drive
Tallahassee, FL 32308
1-888-419-3456, TTY: **1-866-467-4970**
8 a.m. - 5 p.m. ET, Monday - Friday
https://www.flmedicaidmanagedcare.com/home/index

Georgia

Georgia Medicaid
2 Martin Luther King Jr. Drive SE
East Tower
Atlanta, GA 30334
1-866-211-0950, TTY: **711**
8 a.m. - 5 p.m. ET, Monday - Friday
https://medicaid.georgia.gov/

Hawaii

Hawaii Med-QUEST Division Program (Medicaid)
1350 S. King Street
Suite 200
Honolulu, HI 96814
1-800-316-8005, TTY: **711**
7:45 a.m. - 4:30 p.m. HT, Monday - Friday
https://medquest.hawaii.gov/en.html

Idaho

Idaho Medicaid
1720 Westgate Drive
Boise, ID 83704
1-888-528-5861, TTY: **1-888-791-3004**
8 a.m. - 5 p.m. MT, Monday - Friday
https://healthandwelfare.idaho.gov/

Illinois

Illinois Medicaid
201 South Grand Avenue East
Springfield, IL 62763
1-800-843-6154, TTY: **1-855-889-4326**
7:30 a.m. - 7 p.m. CT, Monday - Friday
https://hfs.illinois.gov/medicalclients.html

Indiana

Indiana Medicaid
402 W. Washington Street
P.O. Box 7083
Indianapolis, IN 46204
1-800-457-4584, TTY: **711**
8 a.m. - 4:30 p.m. ET, Monday - Friday
https://www.in.gov/medicaid/

Iowa

Iowa Department of Health and Human Services
1305 E Walnut Street FL 5
Des Moines, IA 50319
1-800-338-8366, TTY: **1-800-735-2942**
8 a.m. - 5 p.m. CT, Monday - Friday
http://dhs.iowa.gov/

Kansas

KanCare
P.O. Box 3599
Topeka, KS 66601-9738
1-800-792-4884, TTY: **1-800-792-4292**
8 a.m. - 7 p.m. CT, Monday - Friday
https://www.kancare.ks.gov/

Kentucky

Kentucky Department for Medicaid Services (DMS)
275 E Main St.
Frankfort, KY 40621
1-800-372-2973, TTY: **1-502-564-3852**
8 a.m. - 4:30 p.m. ET, Monday - Friday
https://www.chfs.ky.gov/agencies/dms/Pages/default.aspx

Louisiana

Healthy Louisiana (Medicaid)
P.O. Box 629
Baton Rouge, LA 70821-0629
1-888-342-6207, TTY: **1-855-526-3346**
8 a.m. - 4:30 p.m. ET, Monday - Friday
https://www.myplan.healthy.la.gov/learn

Maine

MaineCare Services (Medicaid)
242 State St.
Augusta, ME 04333
1-855-797-4357, TTY: **711**
8 a.m. - 5 p.m. ET, Monday - Friday
https://mainecare.maine.gov/Default.aspx

Maryland

Maryland Medicaid
201 W. Preston Street
Baltimore, MD 21201-2399
1-410-767-6500, TTY: **1-800-735-2258**
8:30 a.m. - 5 p.m. Monday - Friday
https://mmcp.health.maryland.gov/Pages/Am%20I%20Eligible.aspx

Massachusetts

MassHealth
PO Box 4405
Taunton, MA 02780
1-800-841-2900, TTY: **711**
8 a.m. - 5 p.m. ET, Monday - Friday
http://www.mass.gov/eohhs/gov/departments/masshealth/

Michigan

Michigan Medicaid
333 S. Grand Ave.
P.O. Box 30195
Lansing, MI 48909
1-517-241-3740, TTY: **1-800-649-3777**
8 a.m. - 5 p.m. ET, Monday - Friday
www.michigan.gov/medicaid

Minnesota

Medical Assistance (MA)
P.O. Box 64993
St. Paul, MN 55164-0993
1-800-366-5411, TTY: **711**
8 a.m. to 4:15 p.m. (closed from noon to 12:45 for lunch), Monday through Friday
https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/medical-assistance.jsp

Mississippi

Mississippi Division of Medicaid (DOM)
550 High Street
Suite 1000
Jackson, MS 39201
1-800-421-2408, TTY: **1-228-206-6062**
8 a.m. - 5 p.m. CT, Monday - Friday
https://medicaid.ms.gov/medicaid-coverage/

Missouri

MO HealthNet (Missouri Medicaid)
615 Howerton Court
P.O. Box 6500
Jefferson City, MO 65102-6500
1-573-751-3425, TTY: **711**
8 a.m. - 5 p.m. CT, Monday - Friday
https://dss.mo.gov/mhd/healthcare-benefit.htm

Montana

Montana Medicaid
111 North Sanders
Helena, MT 59601
1-800-362-8312, TTY: **711**
8 a.m. - 5 p.m. MT, Monday - Friday
http://dphhs.mt.gov/MontanaHealthcarePrograms/MemberServices

Nebraska

Nebraska Medicaid
301 Centennial Mall South
Lincoln, NE 68509
1-855-632-7633, TTY: **1-800 833-7352**
8 a.m. - 5 p.m., Monday - Friday
https://dhhs.ne.gov/Pages/Medicaid-Eligibility.aspx

Nevada

Nevada Medicaid
1100 East William St.
Suite 102
Carson City, NV 89701
1-877-638-3472, TTY: **711**
8 a.m. - 5 p.m. PT, Monday - Friday
https://www.medicaid.nv.gov/

New Hampshire

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

New Jersey

New Jersey Family Care (Medicaid)
200 Woolverton Street
P.O. Box 1450
Trenton, NJ 08650-2099
1-800-701-0710, TTY: **711**
8:00 a.m - 8:00 p.m ET, Monday, Thursday, 8:00 a.m - 5:00 p.m ET, Tuesday, Wednesday, Friday
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/

New Mexico

New Mexico Centennial Care (Medicaid)
P.O. Box 2348
Santa Fe, NM 87504-2348
1-800-283-4465, TTY: **711**
7 a.m. - 6:30 p.m., Monday - Friday
http://www.hsd.state.nm.us/LookingForAssistance/centennial-care-overview.aspx

New York

New York State Medicaid
162 Washington Avenue
Albany, NY 12210
1-800-541-2831, TTY: **1-800-662-1220**
8:00 a.m. - 8 p.m. ET, Monday - Friday, and Saturday from 9:00 a.m. - 1 p.m.
https://www.health.ny.gov/health_care/medicaid/

North Carolina

NC Medicaid
2501 Mail Service Center
Raleigh, NC 27699-2501
1-888-245-0179, TTY: **711**
8 a.m. - 5 p.m. ET, Monday - Friday, Closed on State holidays
https://dma.ncdhhs.gov/medicaid

North Dakota

North Dakota Medicaid
600 E Boulevard Ave
Bismarck, ND 58505-0250
1-701-328-2310, TTY: **711**
8 a.m. - 5 p.m. CT, Monday - Friday
https://www.hhs.nd.gov/medicaid-services

Ohio

Ohio Medicaid
50 West Town Street
Suite 400
Columbus, OH 43215
1-800-324-8680, TTY: **711**
7 a.m. - 8 p.m. ET, Monday - Friday, Saturday 8 a.m. to 5 p.m.
https://medicaid.ohio.gov/home

Oklahoma

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

Oregon

Oregon Health Plan (Medicaid)
P.O. Box 14015
Salem, OR 97309
1-800-699-9075, TTY: **711**
7 a.m. - 6 p.m. PT, Monday - Friday
https://www.oregon.gov/OHA/HSD/OHP/Pages/index.aspx

Pennsylvania

Pennsylvania Medical Assistance (Medicaid)
801 Market St
Philadelphia, PA 19107
1-800-692-7462, TTY: **1-800-451-5886**
8 a.m. - 5:00 p.m. ET, Monday - Friday
https://www.dhs.pa.gov/Services/Assistance/Pages/Medical-Assistance.aspx

Rhode Island

Rhode Island Medicaid
401 Wampanoag Trail
East Providence, RI 02915
1-855-697-4347, TTY: **711**
8:30 am - 3:30 pm Monday-Friday (days and hours of first phone number) 8:00 a.m.- 6:00 p.m. Monday - Friday. (days and hours second phone number)
http://www.eohhs.ri.gov/Consumer/ConsumerInformation.aspx

South Carolina

Healthy Connections Medicaid
P.O. Box 8206
Columbia, SC 29202-8206
1-888-549-0820, TTY: **1-888-842-3620**
8 a.m. - 6 p.m. ET, Monday - Friday
https://www.scdhhs.gov/

South Dakota

South Dakota Medicaid
700 Governors Drive
Pierre, SD 57501
1-800-452-7691, TTY: **711**
8 a.m. - 4:30 p.m. CT, Monday - Friday
http://dss.sd.gov/medicaid/

Tennessee

Tennessee TennCare (Medicaid)
310 Great Circle Rd.
Nashville, TN 37243
1-800-342-3145, TTY: **1-800-848-0299**
7 a.m. - 6 p.m. CT, Monday - Friday
http://www.tn.gov/tenncare/

Texas

Texas Department of Health and Human Services
P.O. Box 149024
Austin, TX 78714-9024
1-877-541-7905, TTY: **711**
8 a.m. - 4 p.m. CT, Monday - Friday
https://hhs.texas.gov/services/health/medicaid-chip

Utah

Utah Medicaid
288 North 1460 West
Salt Lake City, UT 84116
1-866-608-9422, TTY: **711**
8 a.m. - 5 p.m. MT, Monday - Friday; 11 a.m. - 5 p.m. MT, Thursday
https://medicaid.utah.gov/

Vermont

Department of Vermont Health Access (Medicaid)
280 State Dr. NOB 1 South
Waterbury, VT 05671-1010
1-800-250-8427, TTY: **711**
7:45 a.m. - 4:30 p.m. ET, Monday - Friday
https://dvha.vermont.gov/members/medicaid

Virginia

Virginia Medicaid
600 E. Broad St.
Richmond, VA 23219
1-855-242-8282, TTY: **1-888-221-1590**
8 a.m. - 7 p.m. ET, Monday - Friday, 9 a.m. - 12 p.m. ET, Saturday
https://www.dmas.virginia.gov/

Washington

Apple Health (Medicaid)
PO Box 45531
Olympia, WA 98504
1-800-562-3022, TTY: **711**
8 a.m. - 4 p.m. PT, Monday - Friday
https://www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage

West Virginia

West Virginia Medicaid
350 Capitol St
Rm 251
Charleston, WV 25301
1-304-558-1700, TTY: **1-866-430-1274**
8 a.m. - 7 p.m. ET, Monday - Friday, Closed on State holidays
https://dhhr.wv.gov/bms/Pages/default.aspx

Wisconsin

Wisconsin Department of Health Services
1 West Wilson Street
Madison, WI 53703
1-608-266-1865, TTY: **711**
8 a.m. - 4:30 p.m. CT, Monday - Friday
https://www.dhs.wisconsin.gov/health-care-coverage/index.htm

Wyoming

Wyoming Medicaid
122 W 25th St.
Cheyenne, WY 82001
1-307-777-7531, TTY: **1-855-329-5205**
9 a.m. - 5 p.m. MT, Monday - Friday
https://health.wyo.gov/healthcarefin/medicaid

SECTION 4 State Medicare Offices

The following state agency information was updated on 08/01/2025. For more recent information or other questions, call Member Services.

Alabama

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
http://www.medicare.gov

Alaska

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
http://www.medicare.gov

Arizona

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
http://www.medicare.gov

Arkansas

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
http://www.medicare.gov

California

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
http://www.medicare.gov

Colorado

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
http://www.medicare.gov

Connecticut

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
http://www.medicare.gov

Delaware

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
http://www.medicare.gov

District Of Columbia

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
http://www.medicare.gov

Florida

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
http://www.medicare.gov

Georgia

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
http://www.medicare.gov

Hawaii

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
http://www.medicare.gov

Idaho

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
http://www.medicare.gov

Illinois

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
http://www.medicare.gov

Indiana

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
http://www.medicare.gov

Iowa

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
http://www.medicare.gov

Kansas

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
http://www.medicare.gov

Kentucky

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
http://www.medicare.gov

Louisiana

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
http://www.medicare.gov

Maine

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
http://www.medicare.gov

Maryland

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
http://www.medicare.gov

Massachusetts

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
http://www.medicare.gov

Michigan

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
http://www.medicare.gov

Minnesota

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
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Mississippi

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
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Missouri

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
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Montana

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
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Nebraska

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
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Nevada

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
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http://www.medicare.gov

New Hampshire

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
http://www.medicare.gov

New Jersey

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
http://www.medicare.gov

New Mexico

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
http://www.medicare.gov

New York

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
http://www.medicare.gov

North Carolina

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
http://www.medicare.gov

North Dakota

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
http://www.medicare.gov

Ohio

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
http://www.medicare.gov

Oklahoma

Medicare Contact Center Operations
P.O. Box 1270
Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
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http://www.medicare.gov

Oregon

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
http://www.medicare.gov

Pennsylvania

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
http://www.medicare.gov

Rhode Island

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
http://www.medicare.gov

South Carolina

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
http://www.medicare.gov

South Dakota

Medicare Contact Center Operations
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Lawrence, KS 66044
1-800-633-4227, TTY: **1-877-486-2048**
24 hours, 7 days a week
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Tennessee

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
http://www.medicare.gov

Texas

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
http://www.medicare.gov

Utah

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
http://www.medicare.gov

Vermont

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
http://www.medicare.gov

Virginia

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
http://www.medicare.gov

Washington

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
http://www.medicare.gov

West Virginia

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
http://www.medicare.gov

Wisconsin

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
http://www.medicare.gov

Wyoming

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
http://www.medicare.gov

SECTION 5 Civil Rights Commission

The following state agency information was updated on 08/01/2025. For more recent information or other questions, call 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**
8:00 a.m. to 4:30 p.m.
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**
8:00 a.m. to 8:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
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**
7:30 a.m. to 8:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
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 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
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**
9:30 a.m. to 3:30 p.m.
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**
9:30 a.m. to 3:30 p.m.
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**
8:00 a.m. to 4:30 p.m.
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**
8:00 a.m. to 4:30 p.m.
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**
8:00 a.m. to 8:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
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**
8:30 a.m. to 5:00 p.m.
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**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Iowa

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**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Kansas

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**
8:30 a.m. to 5:00 p.m.
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**
8:00 a.m. to 4:30 p.m.
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**
7:30 a.m. to 8:00 p.m.
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 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
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**
9:30 a.m. to 3:30 p.m.
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 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Michigan

Office for Civil Rights of the Midwest Region
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1-800-368-1019, TTY: **1-800-537-7697**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Minnesota

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**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

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
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 4:30 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Missouri

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**
8:30 a.m. to 5:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Nebraska

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**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

New Hampshire

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
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**
8:30 a.m. to 5:00 p.m.
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**
7:30 a.m. to 8:00 p.m.
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**
8:30 a.m. to 5:00 p.m.
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**
8:00 a.m. to 4:30 p.m.
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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Ohio

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**
8:30 a.m. to 5:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oklahoma

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**
7:30 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Oregon

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**
8:00 a.m. to 8:00 p.m.
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**
9:30 a.m. to 3:30 p.m.
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 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

South 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**
8:00 a.m. to 4:30 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

South 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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Tennessee

Office for Civil Rights of the Southeast Region - Atlanta
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Atlanta, GA 30303-8909
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ocrmail@hhs.gov
http://www.hhs.gov/ocr

Texas

Office for Civil Rights of the Southwest Region
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Dallas, TX 75202
1-800-368-1019, TTY: **1-800-537-7697**
7:30 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Utah

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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Vermont

Office for Civil Rights of New England Region
J.F. Kennedy Federal Building, Room 1875
Boston, MA 2203
1-800-368-1019, TTY: **1-800-537-7697**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Virginia

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**
9:30 a.m. to 3:30 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Washington

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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

West Virginia

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**
9:30 a.m. to 3:30 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Wisconsin

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**
8:30 a.m. to 5:00 p.m.
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**
8:00 a.m. to 8:00 p.m.
ocrmail@hhs.gov
http://www.hhs.gov/ocr

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the phone number on your member ID card or speak to your provider.

Spanish – ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono que figura en su tarjeta de identificación del miembro o hable con su proveedor.

Arabic – تنبيه: إذا كنت تتحدث العربية ، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجانا. اتصل على رقم الهاتف الموجود على بطاقة ID هوية العضو الخاصة بك أو تحدث إلى مقدم الخدمة.

Armenian – ՈՒՇԱԴՐՈՒԹՅՈՒՆ. Եթե խոսում եք հայերեն, ձեզ հասանելի են անվճար լեզվական աջակցության ծառայություններ: Մատչելի ձևաչափերով տեղեկատվություն տրամադրելու համար համապատասխան օժանդակ միջոցներն ու ծառայությունները նույնպես հասանելի են անվճար: Զանգահարեք ձեր անդամի ID քարտի վրա նշված հեռախոսահամարով կամ խոսեք ձեր մատակարարի հետ:

Chinese – 注意：如果您說中文，我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請撥打您的會員 ID 卡上的電話號碼或與您的提供者交談。

Farsi – توجه: اگر به زبان فارسی صحبت می‌کنید، خدمات کمک زبانی رایگان در دسترس شما است. وسایل و خدمات کمکی مناسب برای ارائه اطلاعات در قالب‌های مناسب معلولان نیز به‌صورت رایگان قابل ارائه است. با شماره تلفن مندرج روی کارت ID عضویت خود تماس بگیرید یا با ارائه‌دهنده‌تان صحبت کنید.

French – ATTENTION : Si vous parlez français, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone figurant sur votre carte d'ID de membre ou appelez votre prestataire.

Haitian Creole – ATANSYON: Si w pale kreyòl ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòma aksesib yo disponib tou gratis. Rele nimewo telefòn ki sou kat Iantifikasyon manm ou a oswa pale ak founisè w la.

Italian – ATTENZIONE: sono disponibili servizi di assistenza linguistica gratuita in italiano. Sono inoltre disponibili gratuitamente adeguati supporti e servizi per ottenere informazioni in formato accessibile. Chiamare il numero di telefono riportato sulla propria tessera associativa o rivolgersi al proprio fornitore.

Japanese – 注意：日本語を話せる方向けに、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらも無料でご利用いただけます。必要な情報取得にお役立てください。会員IDカードに記載されている電話番号にお電話いただくか、プロバイダーにお問い合わせください。

Korean – 주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 이용하실 수 있습니다. 가입자 ID 카드에 기재된 전화 번호로 전화하거나 담당 의료 제공자에게 문의하십시오.

Polish – UWAGA: Jeśli mówisz po polsku, możesz skorzystać z bezpłatnych usług pomocy językowej. Dostępne są również nieodpłatnie odpowiednie pomoce i usługi zapewniające informacje w dostępnych formatach. Zadzwoń pod numer telefonu podany na karcie ID członka lub porozmawiaj ze swoim dostawcą.

Portuguese – ATENÇÃO: Se fala português, tem à sua disposição serviços de assistência linguística gratuitos. Estão também disponíveis, a título gratuito, ajudas e serviços auxiliares adequados para fornecer informações em formatos acessíveis. Ligue para o número de telefone que consta do seu cartão ID de membro ou fale com seu prestador.

Russian – ВНИМАНИЕ: Если вы говорите на русском языке, вам могут предоставить бесплатные услуги переводчика. Также бесплатно предоставляются вспомогательные средства и услуги, позволяющие получать информацию в доступных форматах. Позвоните по номеру телефона, указанному на вашей ID-карте участника, или обсудите этот вопрос с вашим поставщиком услуг.

Tagalog – PAUNAWA: Kung nagsasalita ka ng Tagalog, may available na mga libreng serbisyong tulong sa wika para sa iyo. Available rin nang libre ang mga naaangkop na auxiliary aid at serbisyo para maibigay ang impormasyon sa alternatibong mga format. Tawagan ang numero ng telepono sa iyong ID card ng miyembro o makipag-usap sa iyong provider.

Vietnamese – CHÚ Ý: Nếu quý vị nói tiếng Việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí luôn sẵn sàng phục vụ quý vị. Các dịch vụ và hỗ trợ phụ trợ thích hợp cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi số điện thoại trên thẻ ID thành viên của quý vị hoặc nói chuyện với nhà cung cấp của quý vị.

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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 for non-English speakers.
TTY:	**711**. This number requires special telephone equipment and is only for people who have difficulties 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.