Anthem BlueCross

Evidence of Coverage

Anthem MediBlue Access (PPO)
Offered by Anthem Blue Cross Life and Health Insurance Company

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2017.

1-877-811-3107, TTY **711**

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Multi-language Interpreter Services

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-811-3107 (TTY: 711).

Spanish: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-811-3107 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-811-3107 (رقم هاتف الصم والبكم: 711).

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-811-3107 (TTY (հեռատիպ)՝ 711):

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-811-3107（TTY：711）。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با1-877-811-3107 (TTY: 711)تماس بگیرید.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-811-3107 (ATS : 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-811-3107 (TTY: 711).

Gujarati: સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-811-3107 (TTY: 711).

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-811-3107 (TTY: 711) पर कॉल करें।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-877-811-3107 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-811-3107 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-811-3107（TTY:711）まで、お電話にてご連絡ください。

Khmer: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-877-811-3107 (TTY: 711)។

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-811-3107 (TTY: 711) 번으로 전화해 주십시오.

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ເສັຽຄ່າ ການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-811-3107 (TTY: 711).

Navajo: D77 baa ak0 n7n7zin: D77 saad bee y1n7[ti'go **Diné Bizaad**, saad bee 1k1'1n7da'1wo'd66', t'11 jiik'eh, 47 n1 h0l=, koj8' h0d77lnih 1-877-811-3107 (TTY: 711.)

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-877-811-3107 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-811-3107 (телетайп: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-811-3107 (TTY: 711).

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-811-3107 (TTY: 711).

Urdu:

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔
1-877-811-3107 (TTY: 711). کال کریں

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-811-3107 (TTY: 711).

Anthem BlueCross

January 1 – December 31, 2017

Evidence of Coverage

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

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2017. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

Anthem Blue Cross Life and Health Insurance Company is an LPPO plan with a Medicare contract. Enrollment in Anthem Blue Cross Life and Health Insurance Company depends on contract renewal.

This information is available for free in other languages. Please contact our Customer Service number at 1-877-811-3107 for additional information. (TTY users should call 711.) Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Customer Service also has free language interpreter services available for non-English speakers.

Esta información está disponible en otros idiomas de manera gratuita. Comuníquese con el número de nuestro Servicio de Atención al Cliente al 1-877-811-3107 para obtener más información. (Los usuarios de TTY deben llamar al 711.) El horario es de 8 a. m. a 8 p. m., los 7 días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.° de octubre hasta el 14 de febrero, y de lunes a viernes (excepto los feriados) desde el 15 de febrero hasta el 30 de septiembre. El Servicio de Atención al Cliente también ofrece los servicios gratuitos de un intérprete para las personas que no hablan inglés.

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

Benefits, premium, deductible and/or copayments/coinsurance may change on January 1, 2018.

The formulary, pharmacy network, and/or provider network may change at any time. You will receive notice when necessary.

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2017 Evidence of Coverage
Table of contents

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

Chapter 1

Getting started as a member

Chapter 1. Getting started as a member

Section 1. Introduction

Section 1.1

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

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

There are different types of Medicare health plans. Anthem MediBlue Access (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.

Section 1.2

What is the *Evidence of Coverage* booklet about?

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

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

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

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

Section 1.3

Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for the months in which you are enrolled in the plan between January 1, 2017 and December 31, 2017.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Anthem MediBlue Access (PPO) after December 31, 2017. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2017.

Medicare must approve our plan each year

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

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

Section 2.1

Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B.)

- *-- and --* you live in our geographic service area (Section 2.3 below describes our service area.)
- *-- and --* you are a United States citizen or are lawfully present in the United States
- *-- and --* you do *not* have end-stage renal disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2

What are Medicare Part A and Medicare Part B?

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

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

Section 2.3

Here is the plan service area for our plan

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

Our service area includes this county in CA: Riverside

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

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

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

Section 2.4

U.S. Citizen or Lawful Presence

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

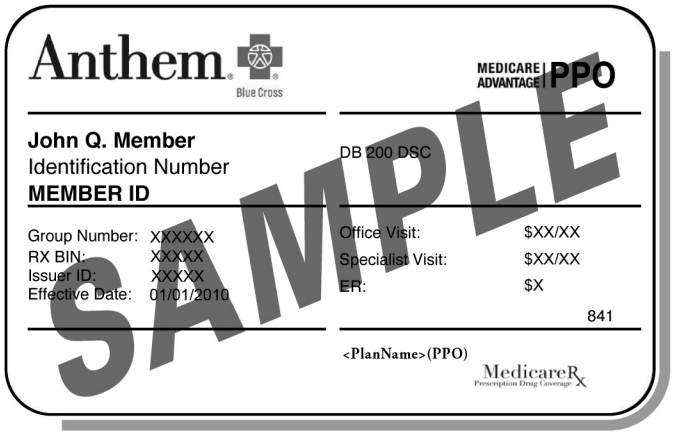
Section 3. What other materials will you get from us?

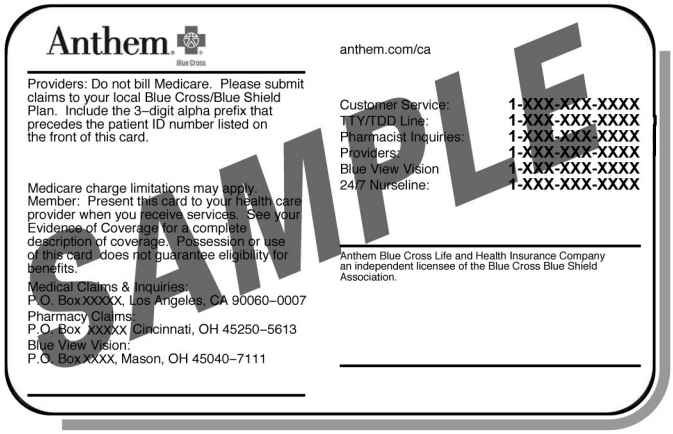
Section 3.1

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

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by this plan and for prescription drugs you get at network pharmacies.

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





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

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

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

Section 3.2

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

The *Provider/Pharmacy Directory* lists our network providers.

What are "network providers"?

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 any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

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

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

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

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

Section 3.3

The *Provider/Pharmacy Directory*: your guide to pharmacies in our network

What are "network pharmacies"?

Network pharmacies are all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use.

There are changes to our network of pharmacies for next year. An updated *Provider/Pharmacy Directory* is located on our website at www.anthem.com/ca. You may also call Customer Service for updated provider information or to ask us to mail you a *Provider/ Pharmacy Directory*. **Please review the 2017 *Provider/Pharmacy Directory* to see which pharmacies are in our network.**

The *Provider/Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies.

If you don't have the *Provider/Pharmacy Directory*, you can get a copy from Customer Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Customer Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.anthem.com/ca.

Section 3.4

The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the *"Drug List"* for short. It tells which Part D prescription drugs are covered under the Part D benefit included in the plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our plan's *Drug List*. The *Drug List* also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the *Drug List*. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.anthem.com/ca) or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 3.5

The *Part D Explanation of Benefits* (the "*Part D EOB*"): reports with a summary of payments made for your Part D prescription drugs

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

The *Part D Explanation of Benefits* tells you the total amount you, or others on your behalf, have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 *(What you pay for your Part D prescription drugs)* gives more information about the *Part D Explanation of Benefits* and how it can help you keep track of your drug coverage.

A *Part D Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Section 4. Your monthly premium for the plan

Section 4.1

How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2017, the monthly premium for our plan is $165.00. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you.** We send you a separate insert, called the "*Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the "*Low-Income Subsidy Rider"* or the "*LIS Rider"*), which tells you about your drug coverage. If you don't receive this insert, please call Customer Service and ask for the "*LIS Rider."* (Phone numbers for Customer Service are printed on the back cover of this booklet.)

In some situations, your plan premium could be *more*

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- If you signed up for extra benefits, also called "optional supplemental benefits," then you pay an additional premium, each month, for these extra benefits. The monthly premium for the Preventive Dental Package is $21.00. The monthly premium for the Dental and Vision Package is $32.00. The monthly premium for the Enhanced Dental and Vision Package is $41.00. If you have any questions about your plan premium, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- Some members are required to pay a **late-enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is at least as good as Medicare's standard drug coverage.) For these members, the late-enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late-enrollment penalty.
  - If you are required to pay the late-enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 9 *explains the late-enrollment penalty.*
  - If you have a late-enrollment penalty and do not pay it, you may be disenrolled from the plan.

Many members are required to pay other Medicare premiums

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

Some people pay an extra amount for Part D because of their yearly income, this is known as Income-Related Monthly Adjustment Amounts, also known as IRMAA. If your income is greater than $85,000 for an individual (or married individuals filing separately) or greater than $170,000 for married couples, **you must pay an extra amount directly to the government (not the Medicare plan)** for your Medicare Part D coverage.

- **If you are required to pay the extra amount, and you do not pay it, you *will* be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 6, Section 10 of this booklet. You can also visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2017* gives information about the Medicare premiums in the section called "2017 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year, in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2017* from the Medicare website (http://www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2

There are several ways you can pay your plan premium

There are three ways you can pay your plan premium. You chose your payment option at the time you enrolled. You can change your payment type at any time. If you would like to change to a different payment option, call Customer Service. Phone numbers are printed on the back cover of this booklet. If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

If you chose to pay directly to our plan, you will receive a billing statement each month.
Please send your payment as soon as possible after you receive the bill. We need to receive the payment no later than the date shown on your invoice. If there is no due date on your invoice, we need to receive the payment no later than the first of the next month. If you did not receive a return envelope, the address for sending your payment is:

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 54587
Los Angeles, CA 90054-0587

Please make your check payable to the plan. Checks should *not* be made out to the Centers for Medicare & Medicaid Services (CMS) or the U.S. Department of Health and Human Services (HHS) and should *not* be sent to these agencies.

Option 2: You can pay by automatic withdrawal

Instead of paying by check, you can have your payment automatically withdrawn from your bank account. You can request a bank account withdrawal request form by calling Customer Service at the phone number printed on the back cover of this booklet. Be sure to attach a blank, voided check when returning your bank account withdrawal request form.

If you have chosen to pay by automatic withdrawal from your bank account, your payment usually will be withdrawn between the 3rd and 9th day of each month. If we receive your request after the monthly withdrawal date has passed, the first payment deducted from your bank account may be for more than one month's premium. Going forward, one month's premium will be withdrawn from your bank account each month.

Option 3: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Customer Service for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first of the month. If we have not received your premium payment by the 15th, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within 90 days. If you are required to pay a late-enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium on time, please contact Customer Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

If we end your membership with the plan because you did not pay your premium, and you don't currently have prescription drug coverage, then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the Annual Enrollment Period. During the Annual Enrollment Period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without "creditable" drug coverage for more than 63 days, you may have to pay a late-enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 1-877-811-3107 between 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. TTY users should call 711. You must

make your request no later than 60 days after the date your membership ends.

Section 4.3

Can we change your monthly plan premium during the year?

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

However, in some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the "Extra Help" program, or, if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay all or part of the member's monthly plan premium. If Medicare pays only a portion of this premium, we will bill you for the amount Medicare doesn't cover. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

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

Section 5.1

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

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

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

Let us know about these changes:

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

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

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

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

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or, if you have other coverage that is not listed, please call Customer Service (phone numbers are printed on the back cover of this booklet).

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

Section 6.1

We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

Section 7. How other insurance works with our plan

Section 7.1

Which plan pays first when you have other insurance?

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

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

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

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

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

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

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

your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

Section 1. Our plan's contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

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

Customer Service – contact information

Call:	1-877-811-3107. Calls to this number are free. From October 1 through February 14, Customer Service representatives will be available to answer your call directly from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. Beginning February 15, Customer Service representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. Our automated system is available any time for self-service options. You can also leave a message after hours and on weekends and holidays. Please leave your phone number and the other information requested by our automated system. A representative will return your call by the end of the next business day. Customer Service also has free language interpreter services available for non-English speakers.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-877-664-1504
Write:	Anthem Blue Cross Life and Health Insurance Company Customer Service P.O. Box 60007 Los Angeles, CA 90060-0007
Website:	www.anthem.com/ca

How to contact us when you are asking for a coverage decision about your medical care or Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or prescription drugs covered under the Part D benefit included in your plan. For more information on asking for coverage decisions about your medical care or Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

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

Coverage decisions for medical care or Part D prescription drugs — contact information

Call:	1-877-811-3107. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-877-664-1504
Write:	Anthem Blue Cross Life and Health Insurance Company Coverage Determinations P.O. Box 60007 Los Angeles, CA 90060-0007
Website:	www.anthem.com/ca

How to contact us when you are making an appeal about your medical care or Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care or Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Appeals for medical care or Part D prescription drugs — contact information

Call:	1-877-811-3107. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-888-458-1406
Write:	Anthem Blue Cross Life and Health Insurance Company - Medicare Advantage Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Website:	www.anthem.com/ca

How to contact us when you are making a complaint about your medical care or Part D prescription drugs

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. If you have a problem about the plan's coverage or payment, you should look at the section above about making an appeal. For more information on making a complaint about your medical care or Part D prescription drugs, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*

Complaints about medical care or Part D prescription drugs – contact information

Call:	1-877-811-3107. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
TTY:	711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.
Fax:	1-888-458-1406
Write:	Anthem Blue Cross Life and Health Insurance Company - Medicare Advantage Appeals and Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare Website:	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs).*

Please note: If you send us a payment request, and we deny any part of your request, you can appeal our decision. See Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* for more information.

Payment requests for medical care — contact information

Call:	1-877-811-3107. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday

to Friday (except holidays) from February 15 through September 30. Calls to this number are free.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Calls to this number are free.

Write: Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

Website: www.anthem.com/ca

Payment requests for Part D prescription drugs — contact information

Call: 1-888-565-8361. Hours are 24 hours a day, 7 days a week. Calls to this number are free.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. Calls to this number are free.

Write: Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

Website: www.anthem.com/ca

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

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

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

Medicare — contact information

Call: 1-800-MEDICARE, or 1-800-633-4227

Calls to this number are free, 24 hours a day, 7 days a week.

TTY: 1-877-486-2048

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

Website: http://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home

health agencies and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

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

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

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

- **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

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

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

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

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

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

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

In California:
California Health Insurance Counseling & Advocacy Program (HICAP) – contact information

Call: 1-800-434-0222

TTY: 1-800-735-2929
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write: California Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive
Suite 200
Sacramento, CA 95834-1992

Website: www.aging.ca.gov/HICAP

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

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

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

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

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

In California:
BFCC-QIO Program – contact information

Call: 1-866-815-5440

TTY: 1-855-887-6668

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

Write: BFCC-QIO Program
9090 Junction Drive
Suite 10
Annapolis Junction, MD 20701

Website: www.BFCCQIOAREA5.com

Section 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end-stage renal disease and meet certain conditions, are eligible for Medicare.

If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount, or, if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

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

Social Security – contact information

Call: 1-800-772-1213
Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY: 1-800-325-0778

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

Website: http://www.ssa.gov

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

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

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

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

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

In California:
Medi-Cal – contact information

Call: 1-800-541-5555

TTY: 711

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

Write: Medi-Cal
820 Stillwater Road
Sacramento, CA 95605-1630

Website: www.medi-cal.ca.gov

Section 7. Information about programs to help people pay for their prescription drugs

Medicare's "Extra Help" program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help," and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining

evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

Please fax or mail a copy of your paperwork showing you qualify for a subsidy using the fax number or address shown on the back cover of this booklet. Below are examples of the paperwork you can provide:

- A copy of your Medicaid card if it includes your eligibility date during the discrepant period;
- A copy of a letter from the state or SSA showing Medicare Low-Income Subsidy status;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A screen print from the state's Medicaid systems showing Medicaid status during the discrepant period;
- Evidence at point-of-sale of recent Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators post point-of-sale.

If you have been a resident of a long-term-care (LTC) facility (like a nursing home), instead of providing one of the items above, you should provide one of the items listed below. If you do, you may be eligible for the highest level of subsidy.

- A remittance from the facility showing Medicaid payment for a full calendar month for you during the discrepant period;
- A copy of a state document that confirms Medicaid payment to the facility for a full calendar month on your behalf; or
- A screen print from the state's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during the discrepant period.

Once we have received your paperwork and verified your status, we will call you so you can begin filling your prescriptions at the low-income copayment.

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D enrollees who have reached the coverage gap and are not receiving "Extra Help." For branded drugs, the 50% discount provided by manufacturers excludes any dispensing fee for costs in the gap. The enrollee would pay the dispensing fee on the portion of the cost, which is paid by the plan (10% in 2017).

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your *Part D Explanation of Benefits (Part D EOB)* will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap. The amount paid by the plan (10%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 49% of the price for generic drugs, and you pay the remaining 51% of the price. For generic drugs, the amount paid by the plan (49%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general,

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

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand-name drugs. Also, the plan pays 10% of the costs of brand drugs in the coverage gap. The 50% discount and the 10% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)? What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance.

Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/under-insured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number.

For information on eligibility criteria, covered drugs or how to enroll in the program, please call:

In California:

California Office of AIDS – contact information

Call: 1-844-421-7050

TTY: 1-800-735-2929

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

Write: California Office of AIDS
P.O. Box 997426
MS 7700
Sacramento, CA 95899-7426

Website: http://www.cdph.ca.gov/programs/aids/Pages/tOAADAP.aspx

What if you get "Extra Help" from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get "Extra Help," you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Part D Explanation of Benefits (Part D EOB)* notice. If the discount doesn't appear on your *Part D Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up to date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs (SPAPs) that help some people pay for prescription drugs based on financial need, age,

medical condition or disabilities. Each state has different rules to provide drug coverage to its members.

In California:
A full-service SPAP is not available in this state.

Section 8. How to contact the Railroad Retirement Board

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

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

Railroad Retirement Board – contact information

Call: 1-877-772-5772

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

TTY: 1-312-751-4701

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

Website: http://www.rrb.gov

Section 9. Do you have "group insurance" or other health insurance from an employer?

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

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

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator**. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Chapter 3

Using the plan's coverage for your medical services

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

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

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

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

Section 1.1

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

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

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

Section 1.2

Basic rules for getting your medical care covered by the plan

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

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

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

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

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

Section 2.1

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

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

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

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

- General practice
- Family Medicine
- Internal Medicine
- Pediatrics

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

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

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

How do you choose your PCP?

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

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

Changing your PCP

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

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

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

membership card that shows the name of your new PCP.

Section 2.2

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

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

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

Section 2.3

How to get care from specialists and other network providers

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

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

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

You are encouraged to get a referral (approval in advance) from your network PCP before you see a network contracted specialist or receive specialty services with the exception of those services listed above under Section 2.2 *What kinds of medical care can you get without getting approval in advance from your PCP?* If you use an out-of-network provider, you pay the out-of-network cost sharing even if you receive a referral for the services, or if you request a pre-visit coverage decision from the plan. In the event that a contracted provider is not available, you can ask to access care at an in-network cost sharing from an out-of-network provider.

Please refer to Chapter 4, Section 2.1 for information about which services require referrals and/or prior authorizations.

For certain services, your PCP will need to get prior approval from us. This is called getting "prior authorization." For exceptions, see the Medical Benefits Chart in Chapter 4.

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

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

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

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

Section 2.4

How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider that is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider, before receiving services, to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, you may want to ask for a previsit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
  - Without a previsit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage, and you will be responsible for the

entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 *(What to do if you have a problem or complaint)* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or, if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do if you receive a bill, or, if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1

Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

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

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

What if it wasn't a medical emergency?

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

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

Section 3.2

Getting care when you have an urgent need for services

What are "urgently needed services"?

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

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

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

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

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

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

Our plan does not cover urgently needed services or any other care if you receive the care outside of the United States.

Section 3.3

Getting care during a disaster

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

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

Generally, during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

Section 4.1

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

If you have paid more than your share for covered services, or, if you have received a bill for the full cost of covered medical services, go to Chapter 7 *(Asking us to pay our share of a bill you have received for covered medical services or drugs)* for information about what to do.

Section 4.2

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

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

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

Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Customer Service to get more information (phone numbers are printed on the back cover of this booklet).

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

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

Section 5.1

What is a "clinical research study"?

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

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of

your care (the care that is not related to the study) through our plan.

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

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

1. We can let you know whether the clinical research study is Medicare approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Customer Service (phone numbers are printed on the back cover of this booklet).

Section 5.2

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

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

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

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

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

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

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

Do you want to know more?

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

Section 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1

What is a religious nonmedical health care institution?

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

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

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

Section 6.2

What care from a religious nonmedical health care institution is covered by our plan?

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

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

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

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

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

Section 7. Rules for ownership of durable medical equipment

Section 7.1

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

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the member. In this section, we discuss other types of durable medical equipment that must be rented.

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

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

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

Chapter 4

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

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

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

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

Section 1.1

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

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

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

Some people qualify for state Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI) and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2

What is your plan deductible?

Your deductible is $1,150.00. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services.

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

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

- In-network primary care physician services
- In-network physician specialist services
- In-network lab services
- In-network chronic obstructive pulmonary disease (COPD) testing
- In-network diabetes monitoring supplies
- In-network preventive services not covered by Original Medicare
- In-network wellness services not covered by Original Medicare
- In-network kidney disease education services
- In-network diabetes self-management training
- In-network Medicare-covered eye exams
- In-network Medicare-covered eye wear
- In-network Medicare-covered hearing exam
- In-network colorectal services

- In-network and out-of-network emergency and urgently needed services
- In-network and out-of-network routine dental benefits not covered under Original Medicare (described in the benefits chart within Section 2).
- In-network and out-of-network routine vision benefits not covered under Original Medicare (described in the benefits chart within Section 2).
- In-network durable medical equipment
- In-network prosthetics and orthotics
- In-network Medicare Part B drugs

Section 1.3

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

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

- Your **in-network maximum out-of-pocket amount** is $6,700. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D prescription drugs and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $6,700 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** is $10,000. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $10,000 for covered services, you will have 100% coverage, and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4

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

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

Here is how this protection works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a

network provider. You will generally have higher copays when you obtain care from out-of-network providers.

- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has "balance billed" you, call Customer Service (phone numbers are printed on the back cover of this booklet).

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

Section 2.1

Your medical benefits and costs as a member of the plan

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

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

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not

participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2017* Handbook. View it online at http://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2017, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Services That Are Covered for You	What You Must Pay When You Get These Services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-Network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for this preventive screening if you are eligible. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply
Ambulance services ▪ Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide	**In- and Out-of-Network:** **$325** copay for each covered one-way ambulance trip via ground or water.

Services That Are Covered for You	What You Must Pay When You Get These Services
care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. ▪ Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**20%** coinsurance as your portion of covered charges for each air ambulance trip. Your provider must get an approval from the plan before you get ground, air or water transportation that's not an emergency. This is called getting prior authorization. Claims received without approval are subject to review and may include a medical necessity evaluation.
Annual routine physical exam The annual routine physical examination provides coverage of additional physical examination services that can only be rendered by a physician, nurse practitioner or physician assistant. These services are not normally covered by Medicare without the billing of a qualified office visit and medical diagnosis. During a routine physical examination, the clinician examines the patient to identify problems through visual inspection, palpation, auscultation and percussion. The last three of these involve direct physical contact with the patient and are necessary to identify the presence (or absence) of a physical condition.	**In-Network:** **$0** copay for the annual routine physical exam. **Out-of-Network:** **40%** as your portion of the covered charges for the annual routine physical exam.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. ***Note:*** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for the annual wellness visit. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the

Services That Are Covered for You	What You Must Pay When You Get These Services
	existing medical condition or other services will also apply.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each bone mass measurement. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Breast cancer screening (mammograms) Covered services include: ▪ One baseline mammogram between the ages of 35 and 39 ▪ One screening mammogram every 12 months for women age 40 and older ▪ Clinical breast exams once every 24 months	**In-Network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each screening mammogram. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$50** copay for each covered therapy visit to treat you if you've had a heart condition.

Services That Are Covered for You	What You Must Pay When You Get These Services
intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You may need an approval from the plan before getting the care. This is called getting a prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each therapy visit to treat you if you've had a heart condition. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	**In-Network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each visit to lower your risk for heart disease If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	**In-Network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for cardiovascular disease testing that is covered once every five years.

Services That Are Covered for You	What You Must Pay When You Get These Services
	If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
 **Cervical and vaginal cancer screening** Covered services include: ▪ For all women: Pap tests and pelvic exams are covered once every 24 months ▪ If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	**In-Network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each Pap and pelvic exams. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Chiropractic services Covered services include: ▪ We cover only manual manipulation of the spine to correct subluxation	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$20** copay for each covered visit to see a chiropractor. Visits that are covered are to adjust alignment problems with the spine. This is called manual manipulation of the spine to fix subluxation. You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. All services must be coordinated by your Primary Care Physician (PCP). **Out-of-Network:**

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$1,150** yearly deductible, you pay **$50** copay for each covered visit to see a chiropractor. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Colorectal cancer screening For people 50 and older, the following are covered: ▪ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months One of the following every 12 months: ▪ Guaiac-based fecal occult blood test (gFOBT) ▪ Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy (or screening barium enema as an alternative) every 24 months Includes the biopsy and removal of any growth during the procedure, in the event the procedure goes beyond a screening exam For people not at high risk of colorectal cancer, we cover: ▪ Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	**In-Network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **$0** copay for a biopsy or removal of tissue during a screening exam of the colon. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for a covered screening to be sure you don't have a colon condition. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: ▪ Routine dental exam	We offer additional coverage as a Supplemental Benefit. Any costs you pay for supplemental dental care will not count toward your maximum out-of-pocket amount. Any claims for this Supplemental Dental Benefit are processed directly by the Dental Vendor.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Routine cleaning	This plan covers the following routine dental services (services not covered under your Medicare base benefit) designed to help prevent disease: ▪ 1 of oral exam every year ▪ 1 cleaning every year **In-Network:** This plan covers these services on an in-network basis only when rendered by a Provider that is part of our Dental Network. Care rendered by a Provider that is not part of our Supplemental Dental Network will be processed as Out-of-Network by the Dental Vendor. **$0** copay for covered preventive dental services designed to help prevent disease. **Out-of-Network:** This plan covers these services on an Out-of-Network basis when rendered by a Provider that is not part our Supplemental Dental Network. **20%** as your portion of the covered charges for dental services designed to help prevent disease. Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 for more options.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	**In-Network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for annual depression screening. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each diabetes screening. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: ▪ Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. ▪ For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. ▪ Diabetes self-management training is covered under certain conditions	**In- and Out-of-Network:** This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Lancets may be purchased at either a pharmacy or Durable Medical Equipment provider. However lancet are limited to the following manufacturers: LifeScan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. If you are using a brand of diabetic test strips, lancets or meters that is not covered by our plan, we will continue to cover it for up to two fills during the first 90 days after joining our company. This 90 day transitional coverage is limited to once per lifetime. During this time, talk with your doctor to decide what brand is medically best for you. Up to 100 test strips per month are covered.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Up to 100 lancets per month are covered. Your provider must get an approval from the plan before we'll pay for test strips or lancets greater than the amount listed above or are not from the approved manufacturers. **In-Network:** **$0** copay for: ▪ Blood glucose test strips. ▪ Urine test strips. ▪ Lancet devices and lancets. ▪ Blood glucose monitors Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. **$0** copay for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider. **$0** copay for covered charges for training to help you learn how to monitor your diabetes. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for: ▪ Blood glucose test strips. ▪ Urine test strips. ▪ Lancet devices and lancets. ▪ Blood glucose monitors Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a DME provider. Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for training to help you learn how to monitor your diabetes.

Services That Are Covered for You	What You Must Pay When You Get These Services
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.anthem.com/ca/medicare.	**In-Network:** **15%** as your portion of the covered charges for durable medical equipment. Your provider must get an approval from the plan before you get some durable medical equipment (DME). This is called getting prior authorization. Items that must get approval include, but not limited to: powered vehicles, power wheelchairs and related items, wheelchairs and beds that are not the usual or standard, continuous glucose monitoring. You must get durable medical equipment through our participating plan suppliers. You cannot purchase these items from a pharmacy. If you receive a durable medical equipment item during an inpatient stay in a hospital or skilled nursing facility, the cost will be included in your inpatient claim. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for durable medical equipment. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Emergency care Emergency care refers to services that are: ▪ Furnished by a provider qualified to furnish emergency services, and ▪ Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention	**In- and Out-of-Network:** **$75** copay for each covered emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.

Services That Are Covered for You	What You Must Pay When You Get These Services
to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.	
Health and wellness education programs These programs are designed to enrich the health and lifestyles of members. ▪ Nurse HelpLine: As a member, you have access to a 24-hour Nurse HelpLine, 7 days a week, 365 days a year. - see Nurse HelpLine for more details. ▪ SilverSneakers® Fitness Program - see SilverSneakers® for more details.	Any costs you pay for health and wellness programs will not count toward your maximum out-of-pocket amount. **$0** copay for health and wellness programs covered by this plan.
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.	**In-Network:** **$35** copay for each covered hearing evaluation to determine if you need medical treatment for a hearing condition. Routine hearing benefits are not covered. Hearing aids are not covered. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered hearing evaluation to determine if you need medical treatment for a hearing condition.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: ▪ One screening exam every 12 months	**In-Network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening. **Out-of-Network:**

Services That Are Covered for You	What You Must Pay When You Get These Services
For women who are pregnant, we cover: ▪ Up to three screening exams during a pregnancy	Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each preventive HIV screening. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: ▪ Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) ▪ Physical therapy, occupational therapy, and speech therapy ▪ Medical and social services ▪ Medical equipment and supplies	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$0** copay for each covered visit from a home health agency. All services must be coordinated by your Primary Care Physician (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered visit from a home health agency. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. **In-Network:** **$5** copay if you get a hospice consultation by a PCP before you elect hospice. **$35** copay if you get a hospice consultation by a specialist before you elect hospice.

Services That Are Covered for You	What You Must Pay When You Get These Services
Covered services include: ▪ Drugs for symptom control and pain relief ▪ Short-term respite care ▪ Home care For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: ▪ If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services ▪ If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by our plan but are not covered by Medicare Part A or B : the plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. For drugs that may be covered by the plan's Part D benefit: Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (What if you're in Medicare-certified hospice).	**Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay a **$35** copay if you get a hospice consultation by a PCP before you elect hospice. Once you meet the **$1,150** yearly deductible, you pay a **$50** copay if you get a hospice consultation by a specialist before you elect hospice.

Services That Are Covered for You	What You Must Pay When You Get These Services
Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Immunizations Covered Medicare Part B services include: ▪ Pneumonia vaccine ▪ Flu shots, once a year in the fall or winter ▪ Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B ▪ Other vaccines if you are at risk and they meet Medicare Part B coverage rules We also cover some vaccines under our Part D prescription drug benefit.	**In-Network:** There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines. The shingles shot is only covered under the Part D drug benefit. The money you have to pay for the shot will depend on the Part D drug benefits found in Chapter 6, section 8. The shingles shot is not covered under the Part B drug benefit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each pneumonia, influenza, and Hepatitis B vaccine. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.	**In-Network:** For covered hospital stays: Once you meet the **$1,150** yearly deductible, you pay for days 1 - 5: **$95** copay per day, for each admission. Once you meet the **$1,150** yearly deductible, you pay for days 6 - 90: **$0** copay per day, for each admission.

Services That Are Covered for You	What You Must Pay When You Get These Services
This Plan covers unlimited inpatient days. Covered services include but are not limited to: ▪ Semi-private room (or a private room if medically necessary) ▪ Meals including special diets ▪ Regular nursing services ▪ Costs of special care units (such as intensive care or coronary care units) ▪ Drugs and medications ▪ Lab tests ▪ X-rays and other radiology services ▪ Necessary surgical and medical supplies ▪ Use of appliances, such as wheelchairs ▪ Operating and recovery room costs ▪ Physical, occupational, and speech language therapy ▪ Inpatient substance abuse services ▪ Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and one companion. The reimbursement for transportation costs are while you and your companion are traveling to and	You pay no copay for additional inpatient hospital days. The hospital should tell the plan within one business day of any emergency admission. Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation, substance abuse, or transplant that you and your doctor planned ahead. This is called getting prior authorization. If you get inpatient care at an out-of-network hospital after your emergency condition is stable, your cost is the cost share you would pay at a network hospital. **Out-of-Network:** For covered hospital stays: Once you meet the **$1,150** yearly deductible, you pay **15%** as your portion of the covered charges for each hospital stay. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive treatment/services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Customer Service. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please go to chapter 7, section 2, How to ask us to pay you back or to pay a bill you have received. ▪ Blood - including storage and administration. Coverage begins with the first pint used. ▪ Physician services ***Note:*** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you	

Services That Are Covered for You	What You Must Pay When You Get These Services
are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1 877 486 2048. You can call these numbers for free, 24 hours a day, 7 days a week.	
Inpatient mental health care Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.	**In-Network:** For covered hospital stays: Once you meet the **$1,150** yearly deductible, you pay for days 1 - 5: **$95** copay per day, for each admission. Once you meet the **$1,150** yearly deductible, you pay for days 6 - 90: **$0** copay per day, for each admission You pay no copay for additional inpatient mental health hospital days in an acute care general hospital. The Plan covers an unlimited number of days in the psychiatric unit of an acute care general hospital, however, there is a 190-day lifetime limit for inpatient services in a Psychiatric hospital. Your provider must get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse or rehab. This is called getting prior authorization. **Out-of-Network:** For covered hospital stays: Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for each hospital stay. The Plan covers an unlimited number of days in the psychiatric unit of an acute care general hospital, however, there is a 190-day

Services That Are Covered for You	What You Must Pay When You Get These Services
	lifetime limit for inpatient services in a psychiatric hospital. Providers not in our network should call the plan to determine coverage before elective inpatient admits. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Inpatient services covered during a non-covered inpatient stay This plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached your SNF coverage limit, the plan will no longer cover your stay in the hospital or SNF. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: ▪ Physician services ▪ Diagnostic tests (like lab tests) ▪ X-ray, radium, and isotope therapy including technician materials and services ▪ Surgical dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices	You must pay the full cost if you stay in a hospital or skilled nursing facility longer than your plan covers. If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this booklet.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition ▪ Physical therapy, speech therapy, and occupational therapy	
LiveHealth Online LiveHealth Online provides convenient access to interact with a doctor via live, two-way video on a computer or mobile device (tablet or smartphone) using a free application. It can be accessed by visiting www.livehealthonline.com. Go to www.livehealthonline.com and click Sign Up ▪ You must enter your health insurance information during enrollment, so have your card ready when you sign up. LiveHealth Online is intended to complement face to face visits with a board certified physician and is available for most types of care. LiveHealth Online is available for use in two different ways: ▪ For conditions such as colds and flu, infections, rashes and allergies, when you cannot get into see your regular doctor, a doctor will be quickly available to see you. ▪ If you need to discuss feelings of depression, stress or anxiousness (mood), you can schedule a future on-line appointment with a psychologist or social worker. Some of the most common conditions covered through LiveHealth Online include: ▪ Cold & Flu symptoms such as cough, fever and headaches ▪ Allergies ▪ Sinus infections	There is a maximum allowance of **$49** for each covered service to treat conditions such as colds and flu, infections, rashes and allergies. For covered services to treat feelings of depression, stress or anxiousness (mood), there is a maximum allowance of **$80** for each visit with a Social Worker and **$95** for each visit with a PhD. **In-Network:** **$0** copay for LiveHealth Online services. **Out-of-Network:** **$0** copay for LiveHealth Online services. However, you pay the difference between the provider's charge and the allowance for covered services.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Bronchitis ▪ Urinary tract infections Access to this service may not be available in all states. For the most up to date list of states go to www.livehealthonline.com. If you are temporarily outside of your service area, benefits are available while in the following states: Alabama, Arizona, California, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming, and the District of Columbia. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this Plan.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-Network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered medical nutrition therapy visit.

Services That Are Covered for You	What You Must Pay When You Get These Services
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: ▪ Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services ▪ Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan ▪ Clotting factors you give yourself by injection if you have hemophilia ▪ Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant ▪ Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug ▪ Antigens ▪ Certain oral anti-cancer drugs and anti-nausea drugs ▪ Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp® or Darbepoetin Alfa) ▪ Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.	**In-Network:** **20%** as your portion of the covered charges for chemotherapy and other drugs covered by Medicare Part B. Your provider must get an approval from the plan before you get certain injectable or infusible drugs. Call the plan to learn which drugs apply. This is called getting prior authorization. Some drugs are covered by Medicare Part B and some are covered by Medicare Part D. Part B drugs do not count toward your Part D initial coverage limit or out-of-pocket limits. You still have to pay your portion of the cost allowed by the plan for a Part B drug whether you get it from a doctor's office or a pharmacy. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for chemotherapy and other drugs covered by Medicare Part B. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.

Services That Are Covered for You	What You Must Pay When You Get These Services
Nurse HelpLine ▪ Nurse HelpLine: As a member, you have access to a 24-hour Nurse HelpLine, 7 days a week, 365 days a year. When you call our nurse 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 HelpLine at 1-855-658-9249. TTY users should call 711.	**$0** copay for the Nurse HelpLine.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-Network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for preventive obesity screening and therapy. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: ▪ X-rays ▪ Radiation (radium and isotope) therapy including technician materials and supplies ▪ Surgical supplies, such as dressings ▪ Splints, casts and other devices used to reduce fractures and dislocations ▪ Laboratory tests ▪ Blood - coverage for storage and administration begins with the first pint of blood that you need.	**In-Network:** **$10** copay for each covered lab service. **$0** copay for tests to confirm chronic obstructive pulmonary disease (COPD). **$0** copayment for Hemoglobin A1c tests or urine tests to check Albumin levels. Once you meet the **$1,150** yearly deductible, you pay **$25** copay for each covered diagnostic procedure or test in a provider's office or freestanding radiology center. Once you meet the **$1,150** yearly deductible, you pay **$125** copay for each covered diagnostic

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Other outpatient diagnostic tests	procedure or test in the outpatient department of a network hospital or facility. Once you meet the **$1,150** yearly deductible, you pay **$25** copay for each covered X-Ray. Once you meet the **$1,150** yearly deductible, you pay **$130** copay for covered diagnostic radiology services. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for covered radiation therapy services. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for covered blood, blood storage, processing and handling services. **15%** as your portion of the covered charges for surgery supplies such as casts and splints. You may have to pay an additional cost for other services received during the visit. Your provider must get an approval from the plan before you get complex imaging or certain diagnostic and therapeutic radiology and lab services. This is called getting prior authorization. These include but are not limited to Radiation therapy, PET, CT, SPECT, MRI scans, Heart tests called Echocardiograms, Diagnostic lab tests, Genetic testing, Sleep studies and related equipment and supplies. All services must be coordinated by your Primary Care Physician (PCP). **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for lab services. Once you meet the **$1,150** yearly deductible, you pay **$0** for tests to confirm COPD.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for Hemoglobin A1c tests or urine tests to check Albumin levels. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for each diagnostic procedure or test. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for covered diagnostic radiology services. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for each covered radiation therapy service. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for covered X-rays. Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for covered blood, blood storage, processing and handling services. Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for surgery supplies such as casts and splints. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: ▪ Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$95** copay for each covered surgery or observation room service in an outpatient hospital. Once you meet the **$1,150** yearly deductible, you pay **$45** copay for each covered partial hospitalization visit for mental health or substance abuse.

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Laboratory and diagnostic tests billed by the hospital ▪ Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it ▪ X-rays and other radiology services billed by the hospital ▪ Medical supplies such as splints and casts ▪ Certain screenings and preventive services ▪ Certain drugs and biologicals that you can't give yourself ***Note:*** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare - Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1 877 486 2048. You can call these numbers for free, 24 hours a day, 7 days a week.	**15%** as your portion of the covered charges for medical supplies such as splints and casts when you get them at a network outpatient facility. Additional copays or coinsurance may apply if other services are received during the same visit. All services must be coordinated by your Primary Care Physician (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for each surgical service or observation room service you get at an outpatient facility. Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each partial hospitalization visit for mental health or substance abuse. Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for medical supplies such as splints and casts when you get them in the outpatient department of a hospital. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation. **In- and Out-of-Network:** You pay the applicable cost sharing amounts as shown elsewhere in this benefit chart for emergency room visits, outpatient diagnostic tests and therapeutic services, and laboratory tests. Please refer to the Medicare Part B Drugs for information on certain drugs and biologicals.

Services That Are Covered for You	What You Must Pay When You Get These Services
	For certain screenings and preventive care services, please refer to the benefits preceded by the "Apple" icon.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$35** copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy. All services must be coordinated by your Primary Care Physician (PCP). You may need an approval from the plan before getting the care. This is called getting a prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay a **$50** copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$25** copay for each covered physical therapy, occupational therapy and speech/language therapy visit. All services must be coordinated by your Primary Care Physician (PCP). Your provider must get an approval from the plan before you get physical therapy, occupational therapy and speech/language therapy. This is called getting a prior authorization. Ask your provider or call the plan to learn more. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **$50** copay for each covered physical therapy,

Services That Are Covered for You	What You Must Pay When You Get These Services
	occupational therapy and speech/language therapy visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient substance abuse services Outpatient and ambulatory substance abuse treatment is supervised by an appropriate licensed professional. Outpatient treatment is provided for individuals or groups, and family therapy may be an additional component. Additional services may be covered in lieu of hospitalization, or as a step-down after hospitalization for substance abuse-related conditions.	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay a **$35** copay for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy. All services must be coordinated by your Primary Care Physician (PCP). Your provider must get an approval from the plan before you get intensive outpatient substance abuse services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered therapy visit. This applies to an individual therapy visit or if the visit is part of group therapy. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers ***Note:*** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$75** as your portion of the covered charges for each covered surgery in an ambulatory surgical center. Once you meet the **$1,150** yearly deductible, you pay **$95** as your portion of the covered charges for each covered surgery or observation room service in an outpatient hospital.

Services That Are Covered for You	What You Must Pay When You Get These Services
you stay in the hospital overnight, you might still be considered an "outpatient."	**$0** copay for a screening exam of the colon that includes a biopsy or removal of any growth or tissue when you get it at an outpatient or ambulatory surgical center in our network. Additional copays or coinsurance may apply if other services are received during the same visit. All services must be coordinated by your Primary Care Physician (PCP). Your provider must get an approval from the plan for select outpatient surgeries and procedures. This is called getting prior authorization **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for each surgery in an ambulatory surgical center. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for each surgery or observation room service in an outpatient hospital. Once you meet the **$1,150** yearly deductible, you pay **50%** as your portion of the covered charges for a screening exam of the colon that includes a biopsy or removal of any growth or tissue when you get it at an outpatient or ambulatory surgical center not in our network. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$45** copay for each covered partial hospitalization visit. Your provider must get an approval from the plan before each partial hospitalization for mental health

Services That Are Covered for You	What You Must Pay When You Get These Services
	or substance abuse. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered partial hospitalization visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Physician/Practitioner services, including doctor's office visits Covered services include: ▪ Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location ▪ Consultation, diagnosis, and treatment by a specialist ▪ Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment ▪ Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare ▪ Second opinion prior to surgery ▪ Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	**In-Network:** **$5** copay for each covered PCP visit. **$35** copay for each covered specialist visit. **$5** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy. Once you meet the **$1,150** yearly deductible, you pay **$0** copay for each covered dental visit for care that is not considered routine. **$35** copay for each covered hearing exam to diagnose a hearing condition. Additional copays or coinsurance may apply if other services are received during the same visit. All services must be coordinated by your Primary Care Physician (PCP). **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay a **$35** copay for each covered PCP visit. Once you meet the **$1,150** yearly deductible, you pay a **$50** copay for each covered specialist visit. Once you meet the **$1,150** yearly deductible, you pay a **$35** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy.

Services That Are Covered for You	What You Must Pay When You Get These Services
	Once you meet the **$1,150** yearly deductible, you pay **$0** copay for each covered dental visit for care that is not considered routine. Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered hearing exam to diagnose a hearing condition. Additional copays or coinsurance may apply if other services are received during the same visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Podiatry services Covered services include: ▪ Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). ▪ Routine foot care for members with certain medical conditions affecting the lower limbs	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$35** copay for each Medicare-covered foot care visit. All services must be coordinated by your Primary Care Physician (PCP). Your provider may need to get an approval from the plan before you get these services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **$50** copay for each Medicare-covered foot care visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: ▪ Digital rectal exam	**In-Network:** There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-Network:**

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ Prostate Specific Antigen (PSA) test	Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each prostate cancer screening. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Prosthetic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery - see "Vision Care" later in this section for more detail.	**In-Network:** **15%** as your portion of the covered charges for covered prosthetic devices and supplies. You must get prosthetic devices and the supplies from a supplier who works with this plan. They will not be covered if you buy them from a pharmacy. If you get a prosthetic or orthotic device while you are getting inpatient services at a hospital or skilled nursing facility, the cost will be included in your inpatient claim. Your provider must get an approval from the plan before you get prosthetic devices and the supplies that go with them. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **35%** as your portion of the covered charges for prosthetic devices, supplies and orthotics. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease	**In-Network:** Once you meet the **$1,150** yearly deductible, you pay **$30** copay for each covered pulmonary rehabilitation visit.

Services That Are Covered for You	What You Must Pay When You Get These Services
(COPD) and order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	Your provider may need to get an approval from the plan before you get pulmonary rehabilitation services. This is called getting prior authorization. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each covered pulmonary rehabilitation visit. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for the screening and counseling to reduce alcohol misuse. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. Eligible enrollees are: people aged 55 - 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years or who currently smoke or have quit	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for counseling and shared decision making visit or for the LDCT.

Services That Are Covered for You	What You Must Pay When You Get These Services
smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the enrollee must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each screening for STIs and counseling to prevent STIs. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Services to treat kidney disease and conditions Covered services include: ▪ Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. ▪ Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) ▪ Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) ▪ Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) ▪ Home dialysis equipment and supplies ▪ Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	**In-Network:** **$0** copay for kidney disease education services. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for kidney dialysis. You pay the inpatient hospital member cost share for dialysis services that you receive while admitted to an inpatient hospital. **$0** copay for dialysis self-training. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for covered dialysis equipment or supplies. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for home support. You do not need to get an approval from the plan before getting dialysis. But we ask that you let the plan know when you need to start this care, so we can assist in coordinating with your doctors. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for kidney disease education services. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for kidney dialysis. You pay the inpatient hospital member cost share for dialysis services that you receive while admitted to an inpatient hospital. Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of covered charges for dialysis self-training. Once you meet the **$1,150** yearly deductible, you pay **20%** as your portion of the covered charges for home support services and home dialysis equipment and supplies.

Services That Are Covered for You	What You Must Pay When You Get These Services
	You do not need to get an approval from the plan before getting dialysis. But we ask that you let the plan know when you need to start this care, so we can assist in coordinating with your doctors.
SilverSneakers The SilverSneakers Fitness Program is a total health and fitness program that is beneficial for Medicare-eligible persons of all fitness levels. Membership allows access to contracted full-service fitness facilities throughout your area. While each fitness facility may vary slightly in amenities, care has been taken to ensure all facilities provide a variety of exercise options. The SilverSneakers Fitness Program Offers: ▪ A SilverSneakers Program Advisor℠ for guidance and assistance ▪ Health education seminars ▪ Access to all equipment and amenities included in a basic fitness membership ▪ Access to over 13,000 fitness locations nationwide ▪ SilverSneakers FLEX. If you're looking for options outside the traditional fitness location. FLEX offers classes and activities in local neighborhood parks, recreation centers; even churches. ▪ SilverSneakers® Steps. An alternative for members who can't get to a SilverSneakers participating location. SilverSneakers Steps is a self-directed physical activity program that allows members to choose one of four available kits to use at home or on the go - general fitness, strength, walking or yoga. The SilverSneakers Fitness Program is not a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers Fitness Program criteria are excluded.	**$0** copay for the SilverSneakers® Fitness Program.

Services That Are Covered for You	What You Must Pay When You Get These Services
To find fitness locations, request your SilverSneakers ID card, enroll in FLEX classes, order a Steps kit or get additional details, visit www.silversneakers.com or call SilverSneakers Customer Service at 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST. The SilverSneakers Fitness Program provided by Healthways, Inc., an independent company. SilverSneakers® is a registered mark of Healthways, Inc.	
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") 100 days per benefit period. No prior hospital stay required. Covered services include but are not limited to: ▪ Semiprivate room (or a private room if medically necessary) ▪ Meals, including special diets ▪ Skilled nursing services ▪ Physical therapy, occupational therapy, and speech therapy ▪ Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) ▪ Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. ▪ Medical and surgical supplies ordinarily provided by SNFs ▪ Laboratory tests ordinarily provided by SNFs	**In-Network:** For covered SNF stays: Once you meet the **$1,150** yearly deductible, you pay for days 1 - 20: **$0** copay per day Once you meet the **$1,150** yearly deductible, you pay for days 21 - 100: **$95** copay per day Cost share is applied starting the day you are formally admitted as an inpatient in a Hospital or Skilled Nursing Facility. Cost share does not apply to the day you are discharged. A benefit period starts on the first day you stay in a skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit on how many benefit periods you can have. Your provider must get approval from the plan before you get skilled nursing care. This is called getting prior authorization. The hospital should tell the plan within one business day of any emergency admission. **Out-of-Network:** For covered SNF stays:

Services That Are Covered for You	What You Must Pay When You Get These Services
▪ X-rays and other radiology services ordinarily provided by SNFs ▪ Use of appliances such as wheelchairs ordinarily provided by SNFs ▪ Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. ▪ A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). ▪ A SNF where your spouse is living at the time you leave the hospital.	Once you meet the **$1,150** yearly deductible, you pay **15%** as your portion of the covered charges for each SNF stay. You or your provider are encouraged to get prior approval from the plan for this service. Claims received without approval are subject to review and may include a medical necessity evaluation.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits.	**In-Network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for each smoking and tobacco use cessation. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply.

Services That Are Covered for You	What You Must Pay When You Get These Services
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.	**In- and Out-of-Network:** **$30** copay for each covered urgently needed service.
Vision care Covered services include: ▪ Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/ contacts. ▪ For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. ▪ For people with diabetes, screening for diabetic retinopathy is covered once per year. ▪ One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Additional vision services that this plan covers that are not covered by Original Medicare are: ▪ Routine eye exam	**In-Network:** **$0** copay for each covered office exam to treat an eye condition that does not qualify as one of the services below. After you have covered cataract surgery, you pay a **$0** copay for one pair of standard eyeglasses or contact lenses after this surgery to treat clouding of the eye lens. Eye examinations are important as some problems do not have symptoms. Early identification is important. Your doctor will determine what tests are important for you and to help you get these important exams we offer the following specific cost sharing for services specifically performed. Consult your physician to determine if you qualify. **$0** copay for a dilated retinal examination with a visual to check for things like Diabetic retinopathy for people with diabetes, macular degeneration, glaucoma and others. Your provider must include code 2022F to report the use of dilation during the exam. **$0** copay for remote imaging for detection of retinal disease (e.g., retinopathy in a patient with diabetes). Your provider will bill with code 92227 or 92228.

Services That Are Covered for You	What You Must Pay When You Get These Services
	$0 copay for a covered glaucoma test. This is Preventive test to see if you have increased pressure inside the eye that causes vision problems and the provider will bill as G0117 or G0118. Your medical vision benefit does not include a routine eye exam (Refraction) for the purpose of prescribing glasses. If you have coverage under a supplemental benefit you will see that information below. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **$0** copay for each covered exam to treat an eye condition. Once you meet the **$1,150** yearly deductible, you pay a **$0** copay for one pair of standard covered eyeglasses or contact lenses after each cataract surgery. This is surgery to treat clouding of the eye lens. In-Network and Out-of-Network Routine Services: Any costs you pay for covered routine vision services will not count toward your maximum out-of-pocket amount. This is a supplemental benefit. In-network routine eye exam benefits are available only through Blue View Vision Insight Network providers. Benefits available under this plan cannot be combined with any other in store discounts. **$0** copay for 1 routine eye exam every calendar year. The plan will pay up to **$69** for routine eye exams every calendar year. Additional copays or coinsurance may apply if other services are received during the same visit. After the plan paid benefits are exhausted you are responsible for the remaining cost. Please see Optional Supplemental Benefits located in Chapter 4 Section 2.2 for additional coverage options.

Services That Are Covered for You	What You Must Pay When You Get These Services
Visitor/Traveler Visitor/Traveler The visitor/traveler program provides access to in-network level of benefits for plan covered services when you are traveling outside our service area for up to 12 months. Network and Service Area restrictions apply.	See Section 2.3 of this chapter for more detail.
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. ***Important:*** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	**In-Network:** There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit. If you also are treated for an existing medical condition during the preventive service, or if other services are billed in addition to the preventive service, the cost sharing for the care received for the existing medical condition or other services will also apply. **Out-of-Network:** Once you meet the **$1,150** yearly deductible, you pay **40%** as your portion of the covered charges for the "Welcome to Medicare" preventive visit.

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

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

Section 2.2

Extra "optional supplemental" benefits you can buy

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

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

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

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

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

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

Optional supplemental benefits	What you must pay when you get these services
Optional supplemental package 1 – Preventive dental package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 1 – Preventive Dental Package.	
Premium	$21.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes):	**In- and Out-of-Network:** The plan will pay up to $500 for preventive dental benefits each year (benefit maximum).

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

Optional supplemental benefits	What you must pay when you get these services
	charges, which are not always billed charges by the provider. ▪ Not all of the Plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.
Optional supplemental package 2 – Dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 2 – Dental and Vision Package.	
Premium	$32.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): ▪ D0120 – Periodic oral evaluation – established patient ▪ D0140 – Limited oral evaluation – problem focused ▪ D0150 – Comprehensive oral evaluation – new or established patient ▪ D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. ▪ D0210 – Intraoral – complete series (including bitewings) ▪ D0220 – Intraoral – periapical first radiographic image ▪ D0230 – Intraoral – periapical each additional radiographic image	**In- and Out-of-Network:** The plan will pay up to $1,000 for dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **Preventive dental services** **In-Network:** **You pay no copay** for the in-network preventive dental benefits listed. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim for covered benefits. **Out-of-Network:** **You pay 30%** of the provider's charges as your portion for the preventive dental benefits listed when you do not

Optional supplemental benefits	What you must pay when you get these services
▪ D0270 – Bitewings – single film ▪ D0272 – Bitewings – two films ▪ D0274 – Bitewings – four films ▪ D0330 – Panoramic film Two cleanings per year ▪ D1110 – Prophylaxis – adult Two fluoride treatments per year ▪ D1208 – Topical application of fluoride **Restorative dental services (fillings)** include the following procedures: ▪ D2140 – Amalgam – one surface, primary or permanent ▪ D2150 – Amalgam – two surfaces, primary or permanent ▪ D2160 – Amalgam – three surfaces, primary or permanent ▪ D2161 – Amalgam – four or more surfaces, primary or permanent ▪ D2330 – Resin-based composite – one surface, anterior ▪ D2331 – Resin-based composite – two surfaces, anterior ▪ D2332 – Resin-based composite – three surfaces, anterior ▪ D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior) ▪ D2391 – Resin-based composite – one surface, posterior ▪ D2392 – Resin-based composite – two surfaces, posterior ▪ D2393 – Resin-based composite – three surfaces, posterior ▪ D2394 – Resin-based composite – four or more surfaces, posterior **Endodontic, periodontic and oral surgery services** include the following procedures: ▪ D7111 – Extraction, coronal remnants – deciduous tooth ▪ D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	use a LIBERTY Dental (Guardian) provider. **Restorative dental services (fillings)** **In-Network:** **You pay 20%** for in-network restorative dental services. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need to submit a claim form for covered benefits. **Out-of-Network:** **You pay 60%** of the Provider's charges as your portion for the restorative dental services listed when you do not use a LIBERTY Dental (Guardian) provider. **Endodontic, periodontic and oral surgery services** Endodontic, periodontic and oral surgery dental services include, but are not limited to, the following: ▪ Root canal treatment ▪ Periodontal scaling and root planing ▪ Simple and surgical extractions (limited to once per tooth per lifetime) **In-Network:** **You pay 50%** for in-network endodontic, periodontic and oral surgery services. When obtaining services from a LIBERTY Dental (Guardian) provider, you will not need

Optional supplemental benefits	What you must pay when you get these services
▪ D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone and/or section of tooth ▪ D7220 – Removal of impacted tooth – soft tissue ▪ D7230 – Removal of impacted tooth – partially bony ▪ D7240 – Removal of impacted tooth – completely bony ▪ D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications ▪ D7250 – Surgical removal of residual tooth roots (cutting procedure) ▪ D3110 – Pulp cap – direct (excluding final restoration) ▪ D3120 – Pulp cap – indirect (excluding final restoration) ▪ D3220 – Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction & application of medicament ▪ D3221 – Pulpal debridement, primary & permanent teeth ▪ D3310 – Root canal – anterior (excluding final restoration) ▪ D3320 – Root canal – bicuspid (excluding final restoration) ▪ D3330 – Root canal – molar (excluding final restoration) ▪ D3346 – Retreatment of previous root canal therapy – anterior ▪ D3347 – Retreatment of previous root canal therapy – bicuspid ▪ D3348 – Retreatment of previous root canal therapy – molar ▪ D3351 – Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) ▪ D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3353 – Apexification/recalcification – final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3410 – Apicoectomy/periradicular surgery – anterior ▪ D3421 – Apicoectomy/periradicular surgery – bicuspid (first root)	to submit a claim form for covered benefits. **Out-of-Network:** **You pay 75%** of the provider's charges as your portion for endodontic, periodontic and oral surgery services when you do not use a LIBERTY Dental (Guardian) provider. **Exclusions & Limitations when rendered by in-network LIBERTY Dental (Guardian) providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. ▪ Dentures and crowns are not covered under this package. ▪ Contracted LIBERTY Dental (Guardian) providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims to LIBERTY Dental (Guardian) directly. ▪ Out-of-network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. ▪ Not all of the Plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered.

Optional supplemental benefits	What you must pay when you get these services
▪ D3425 – Apicoectomy/periradicular surgery – molar (first root) ▪ D3430 – Retrograde filling – per root ▪ D3450 – Root amputation – per root ▪ D3920 – Hemisection (including any root removal), not including root canal therapy ▪ D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4270 – Pedicle soft tissue graft procedure ▪ D4341 – Periodontal scaling & root planing – four or more teeth per quadrant ▪ D4342 – Periodontal scaling & root planing – one to three teeth per quadrant ▪ D4355 – Full mouth debridement to enable comprehensive evaluation & diagnosis ▪ D4910 – Periodontal maintenance	▪ Your costs for these services will not count toward your maximum out-of-pocket amount.
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: ▪ A routine eye exam is covered under your medical benefits once per calendar year.	**In- and Out-of-Network:** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **In-Network:**

Optional supplemental benefits	What you must pay when you get these services
▪ Post cataract surgery and associated eyewear is covered under your medical benefits.	You can select the option of: ▪ Paying a $10 copay for 1 pair of standard plastic (single, bifocal or trifocal) lenses and receiving a retail allowance of $100 for 1 eyeglass frame every calendar year. OR ▪ Alternatively, if you want contact lenses instead of eyeglass lenses and frames, the plan will cover up to $150 for contact lenses every calendar year. When getting covered services from Blue View Vision Insight network providers, you will not need to submit a claim form. **Out-of-Network:** When you choose not to use a Blue View Vision Insight network provider you will be reimbursed for: ▪ 1 pair of lenses per calendar year up to: ▪ $32 for single-vision lenses, or ▪ $48 for bifocal lenses, or ▪ $85 for trifocal lenses AND ▪ up to $100 for 1 eyeglass frame per calendar year OR Alternatively, if you want contact lenses instead of eyeglass lenses and frames:

Optional supplemental benefits	What you must pay when you get these services
	▪ You can be reimbursed up to $150 for contact lenses (in lieu of eyeglass lenses) per calendar year. **Exclusions & Limitations for this benefit package when rendered by in-network Blue View Vision Insight providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. ▪ Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered. ▪ Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider directly for availability. ▪ Contracted Blue View Vision Insight providers will bill directly for covered services. However out-of-network providers may require you to submit the claims to Blue View Vision Insight directly. ▪ Not all of the Plan's medical providers are affiliated with Blue View Vision Insight. Talk to your provider and confirm all coverage, costs and codes prior to services being rendered.

Optional supplemental benefits	What you must pay when you get these services
	▪ Your costs for these services will not count toward your maximum out-of-pocket amount.
Optional supplemental package 3 – Enhanced dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 3 – Enhanced Dental and Vision Package.	
Premium	$41.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): ▪ D0120 – Periodic oral evaluation – established patient ▪ D0140 – Limited oral evaluation – problem focused ▪ D0150 – Comprehensive oral evaluation – new or established patient ▪ D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. ▪ D0210 – Intraoral – complete series (including bitewings) ▪ D0220 – Intraoral – periapical first radiographic image ▪ D0230 – Intraoral – periapical each additional radiographic image ▪ D0270 – Bitewings – single film ▪ D0272 – Bitewings – two films ▪ D0274 – Bitewings – four films ▪ D0330 – Panoramic film Two cleanings per year	**In-and Out-of-Network:** The plan will pay up to $1,500 for dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **Preventive dental services** **In-Network:** **You pay no copay** for in-network preventive dental benefits when using LIBERTY Dental (Guardian) providers. **Out-of-Network:** **You pay 30%** of the provider's charges as your portion for the preventive dental benefits listed when you do not use a LIBERTY Dental (Guardian) provider. **Restorative dental services (fillings)** **In-Network:** **You pay 20%** for in-network restorative dental services when using LIBERTY Dental (Guardian) providers.

Optional supplemental benefits	What you must pay when you get these services
▪ D1110 – Prophylaxis – adult Two fluoride treatments per year ▪ D1208 – Topical application of fluoride **Restorative dental services (fillings)** include the following procedures: ▪ D2140 – Amalgam – one surface, primary or permanent ▪ D2150 – Amalgam – two surfaces, primary or permanent ▪ D2160 – Amalgam – three surfaces, primary or permanent ▪ D2161 – Amalgam – four or more surfaces, primary or permanent ▪ D2330 – Resin-based composite – one surface, anterior ▪ D2331 – Resin-based composite – two surfaces, anterior ▪ D2332 – Resin-based composite – three surfaces, anterior ▪ D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior) ▪ D2391 – Resin-based composite – one surface, posterior ▪ D2392 – Resin-based composite – two surfaces, posterior ▪ D2393 – Resin-based composite – three surfaces, posterior ▪ D2394 – Resin-based composite – four or more surfaces, posterior **Endodontic, periodontic, oral surgery, crowns, dentures, denture repair, relining, and rebasing, and anesthesia services** include the following procedures: ▪ D2740 – Crown – porcelain/ceramic substrate ▪ D2750 – Crown – porcelain fused to high noble metal ▪ D2751 – Crown – porcelain fused to predominantly base metal ▪ D2752 – Crown – porcelain fused to noble metal ▪ D2790 – Crown – full cast high noble metal ▪ D2791 – Crown – full cast predominantly base metal ▪ D2792 – Crown – full cast noble metal	**Out-of-Network:** **You pay 60%** of the provider's charges as your portion for the restorative dental services listed when you do not use a LIBERTY Dental (Guardian) provider. **Endodontic, periodontic and oral surgery services** Endodontic, periodontic and oral surgery dental services include, but are not limited to, the following: ▪ Root canal treatment ▪ Periodontal scaling and root planing ▪ Simple and surgical extractions (limited to once per tooth per lifetime) **In-Network:** **You pay 50%** for in-network endodontic, periodontic and oral surgery services when using LIBERTY Dental (Guardian) providers. **Out-of-Network:** **You pay 75%** of the provider's charges as your portion for the endodontic, periodontic and oral surgery services when you do not use a LIBERTY Dental (Guardian) provider. **Exclusions & Limitations for this benefit package when rendered by in-network LIBERTY Dental (Guardian) providers or out-of-network providers:**

Optional supplemental benefits	What you must pay when you get these services
▪ D2910 – Recement inlay, onlay, or partial coverage restoration ▪ D2915 – Recement cast or prefabricated post & core ▪ D2920 – Recement crown ▪ D2940 – Sedative filling ▪ D2950 – Core buildup, including any pins ▪ D2951 – Pin retention - per tooth, in addition to restoration ▪ D2952 – Post & core in addition to crown, indirectly fabricated ▪ D2954 – Prefabricated post & core in addition to crown ▪ D2955 – Post removal (not in conjunction with endodontic therapy) ▪ D3110 – Pulp cap – direct (excluding final restoration) ▪ D3120 – Pulp cap – indirect (excluding final restoration) ▪ D3220 – Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction & application of medicament ▪ D3221 – Pulpal debridement, primary & permanent teeth ▪ D3310 – Root canal – anterior (excluding final restoration) ▪ D3320 – Root canal – bicuspid (excluding final restoration) ▪ D3330 – Root canal – molar (excluding final restoration) ▪ D3346 – Retreatment of previous root canal therapy – anterior ▪ D3347 – Retreatment of previous root canal therapy – bicuspid ▪ D3348 – Retreatment of previous root canal therapy – molar ▪ D3351 – Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) ▪ D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	▪ You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. ▪ Dentures and crowns are not covered under this package. ▪ Contracted LIBERTY Dental (Guardian) providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims to LIBERTY Dental (Guardian) directly. ▪ Out-of-network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. ▪ Not all of the Plan's medical providers are affiliated with LIBERTY Dental (Guardian). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.

Optional supplemental benefits	What you must pay when you get these services
▪ D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) ▪ D3410 – Apicoectomy/periradicular surgery – anterior ▪ D3421 – Apicoectomy/periradicular surgery – bicuspid (first root) ▪ D3425 – Apicoectomy/periradicular surgery – molar (first root) ▪ D3430 – Retrograde filling – per root ▪ D3450 – Root amputation – per root ▪ D3920 – Hemisection (including any root removal), not including root canal therapy ▪ D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant ▪ D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant ▪ D4270 – Pedicle soft tissue graft procedure ▪ D4341 – Periodontal scaling & root planing – four or more teeth per quadrant ▪ D4342 – Periodontal scaling & root planing – one to three teeth per quadrant ▪ D4355 – Full mouth debridement to enable comprehensive evaluation & diagnosis ▪ D4910 – Periodontal maintenance	

Optional supplemental benefits	What you must pay when you get these services
▪ D5110 – Complete denture – maxillary ▪ D5120 – Complete denture – mandibular ▪ D5130 – Immediate denture – maxillary ▪ D5140 – Immediate denture – mandibular ▪ D5211 – Maxillary partial denture – resin base (including any conventional clasps, rests & teeth) ▪ D5212 – Mandibular partial denture – resin base (including any conventional clasps, rests & teeth) ▪ D5213 – Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth) ▪ D5214 – Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth) ▪ D5421 – Adjust partial denture – maxillary ▪ D5422 – Adjust partial denture – mandibular ▪ D5510 – Repair broken complete denture base ▪ D5520 – Replace missing or broken teeth – complete denture (each tooth) ▪ D5610 – Repair resin denture base ▪ D5620 – Repair cast framework ▪ D5630 – Repair or replace broken clasp ▪ D5640 – Replace broken teeth – per tooth ▪ D5650 – Add tooth to existing partial denture ▪ D5660 – Add clasp to existing partial denture ▪ D5670 – Replace all teeth & acrylic on cast metal framework (maxillary) ▪ D5671 – Replace all teeth & acrylic on cast metal framework (mandibular) ▪ D5710 – Rebase complete maxillary denture	

Optional supplemental benefits	What you must pay when you get these services
▪ D5711 – Rebase complete mandibular denture ▪ D5720 – Rebase maxillary partial denture ▪ D5721 – Rebase mandibular partial denture ▪ D5730 – Reline complete maxillary denture (chairside) ▪ D5731 – Reline complete mandibular denture (chairside) ▪ D5740 – Reline maxillary partial denture (chairside) ▪ D5741 – Reline mandibular partial denture (chairside) ▪ D5750 – Reline complete maxillary denture (laboratory) ▪ D5751 – Reline complete mandibular denture (laboratory) ▪ D5760 – Reline maxillary partial denture (laboratory) ▪ D5761 – Reline mandibular partial denture (laboratory) ▪ D5850 – Tissue conditioning, maxillary ▪ D5851 – Tissue conditioning, mandibular ▪ D7111 – Extraction, coronal remnants – deciduous tooth ▪ D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) ▪ D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth ▪ D7220 – Removal of impacted tooth – soft tissue ▪ D7230 – Removal of impacted tooth – partially bony ▪ D7240 – Removal of impacted tooth – completely bony ▪ D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications ▪ D7250 – Surgical removal of residual tooth roots (cutting procedure) ▪ D7260 – Orolantral fistula closure ▪ D7261 – Primary closure of a sinus perforation ▪ D7280 – Surgical access of an unerupted tooth	

Optional supplemental benefits	What you must pay when you get these services
▪ D7282 – Mobilization of erupted or malpositioned tooth to aid eruption ▪ D7283 – Placement of device to facilitate eruption of impacted tooth ▪ D7285 – Biopsy of oral tissue-hard (bone, tooth) ▪ D7286 – Biopsy of oral tissue – soft ▪ D7287 – Exfoliative cytological sample collection ▪ D7288 – Brush biopsy – transepithelial sample collection ▪ D7310 – Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant ▪ D7311 – Alveloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant ▪ D7320 – Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant ▪ D7321 – Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant ▪ D7410 – Excision of benign lesion of up to 1.25 Cm ▪ D7411 – Excision of benign lesion greater than 1.25 Cm ▪ D7412 – Excision of benign lesion, complicated ▪ D7450 – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 Cm ▪ D7451 – Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 Cm ▪ D7460 – Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 Cm ▪ D7461 – Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 Cm ▪ D7465 – Destruction of lesion(s) by physical or chemical method, by report ▪ D7510 – Incision and drainage of abscess – intraoral soft tissue	

Optional supplemental benefits	What you must pay when you get these services
▪ D7511 – Incision and drainage of abscess – intraoral soft tissue –complicated (includes drainage of multiple facial spaces) ▪ D7520 – Incision and drainage of abscess – extraoral soft tissue ▪ D7521 – Incision and drainge of abscess – extraoral soft tissue – complicated (includes drainage of multiple facial spaces) ▪ D7530 – Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue ▪ D7540 – Removal of reaction-producing foreign bodies, muscoskeletal system ▪ D7960 – Frenulectomy (frenectomy or frenotomy) – separate procedure ▪ D7963 – Frenuloplasty ▪ D9110 – Pallative treatment ▪ D9120 – Fixed partial denture sectioning ▪ D9210 – Local anesthesia not in conjunction with operative or surgical procedure ▪ D9211 – Regional block anesthesia ▪ D9212 – Trigeminal division block anesthesia ▪ D9215 – Local anesthesia ▪ D9220 – Deep sedation/general anesthesia – first 30 minutes ▪ D9221 – Deep sedation/genereal anesthesia – each additional 15 minutes ▪ D9230 – Analgesia, anxiolysis, inhalation of nitrous oxide ▪ D9241 – Intravenous conscious sedation/analgesia – first 30 minutes ▪ D9242 – Intravenous conscious sedation/analgesia each additional 15 minutes ▪ D9248 – Nonintravenous conscious sedation ▪ D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	

Optional supplemental benefits	What you must pay when you get these services
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: ▪ A routine eye exam is covered under your medical benefits once per calendar year. ▪ Post cataract surgery and associated eyewear is covered under your medical benefits.	**In- and Out-of-Network:** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. **In-Network:** You can select the option of: ▪ Paying a $10 copay for 1 pair of standard plastic (single, bifocal or trifocal) lenses and receiving a retail allowance of $150 for 1 eyeglass frame every calendar year. OR ▪ Alternatively, if you want contact lenses instead of eyeglass lenses and frames, the plan will cover up to $200 for contact lenses every calendar year. When getting covered services from Blue View Vision Insight network providers, you will not need to submit a claim form. **Out-of- Network:** When you choose not to use a Blue View Vision Insight network provider, you will be reimbursed for one pair of lenses per calendar year up to: ▪ $32 for single vision lenses, or ▪ $48 for bifocal lenses, or ▪ $85 for trifocal lenses AND ▪ up to $150 for 1 eyeglass frame per calendar year

Optional supplemental benefits	What you must pay when you get these services
	OR Alternatively, if you want contact lenses instead of eyeglass lenses and frames: ▪ You can be reimbursed up to $200 for contact lenses per calendar year. **Exclusions & Limitations for this benefit package when rendered by in-network Blue View Vision Insight providers or out-of-network providers:** ▪ You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. ▪ Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered. ▪ Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider directly for availability. ▪ Contracted Blue View Vision Insight providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims to Blue View Vision Insight directly. ▪ Not all of the Plan's medical providers are affiliated with Blue View Vision Insight. Talk to your provider and confirm all coverage,

Optional supplemental benefits	What you must pay when you get these services
	costs and codes prior to services being rendered. ▪ Your costs for these services will not count toward your maximum out-of-pocket amount.

Section 2.3

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

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

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

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

In addition, members may:

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

When you see Medicare Advantage PPO providers in any geographic area where the visitor/traveler program is offered, you will pay the same cost-sharing level (in-network cost sharing) you would pay if you received covered benefits from in-network providers in your service area. Please see the Medical Benefits Chart for cost sharing information.

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

Section 3.1

Services we do *not* cover (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

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

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
require skilled medical care or skilled nursing care.		
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		✓ This may be covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Additionally, this is covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.		✓ Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. This plan may cover routine dental care if specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit or purchased as part of an optional supplemental benefit package. To utilize this benefit you must use a provider who participates in our routine dental provider network.
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Routine chiropractic care		✓ Manual manipulation of the spine to correct a subluxation is covered, if medically necessary and provided by a chiropractor or an other qualified provider. Medicare doesn't

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		cover routine chiropractic care. This plan may cover additional routine chiropractic care if specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine chiropractic provider network.
Routine foot care		✓ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Medicare covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, and heel spurs), but generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, or hygienic or other preventive maintenance, including cleaning and soaking the feet). This plan may cover additional routine foot care if specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine podiatry provider network.
Home-delivered meals	✓	
Orthopedic shoes		✓ Medicare has limited coverage for those who have diabetes and severe diabetic foot disease. If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease. A podiatrist or other qualified doctor must prescribe these items.
Supportive devices for the feet		✓ Orthopedic or therapeutic shoes for people with diabetic foot disease.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
dysfunction, impotence and anorgasmy or hyporgasmy.		
Over-the-counter purchases		✓ This plan may cover over-the-counter (OTC) items if specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our OTC provider network, limitations and exclusions may apply.
Wigs (even if needed due to a covered medical condition)	✓	
Providers who are prohibited from being covered under the Medicare program for any reason.	✓	
Worldwide Care		✓ Medicare generally doesn't cover health care while you're traveling outside the U.S. and its territories. There are some exceptions offered in limited circumstances as per Medicare guidelines. This plan may cover health care you get while traveling outside the U.S. if specified in the Chapter 4 Medical Benefits Chart located in the Emergency Care or Urgently Needed Care sections.
Prescription drugs you buy outside the U.S.	✓	
Non-participating providers or vendors		✓ Some supplemental benefits utilize a specific Vendor and providers who participate with that Vendor. Providers that participate with the plan may or may not be associated with that Vendor. You may call the plan prior to services being rendered with any questions. To be covered in network, you must use a provider that participates with that Vendor as identified in the provider directory. There may be other exceptions, see Chapter 3

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		(Using the plan's coverage for your medical services) for more information.
Services ordered or administered that are determined to not be a Medicare covered benefit in accordance with Medicare guidelines and the Social Security Act.	✓	
Lab, Radiological & Genetic Testing		✓ We follow Medicare guidelines when determining if Lab, Radiological & Genetic Testing services are covered, even if ordered by a physician. You have the right to contact the plan prior to services being rendered to determine if the services will be covered for your condition (see Organization Determination).
Services performed by out-of-network providers.		✓ This plan covers services of out-of-network providers. You are responsible for verifying provider network status prior to receiving services. In-network providers and facilities are listed in the Provider Directory or online at www.anthem.com/ca. The use of an out of network provider will apply the out of network provider cost share (even approved) unless considered urgent/emergent (required immediately) or when approved in advance for in-network cost sharing. Please see Chapter 3, section 2.4 How to get care from out-of-network providers for more information.
Non-emergency ambulance trips		✓ Medicare does not pay for transportation, including non-emergency ambulance transportation to and from dialysis, unless the Medicare definition of bed-confined is met and documented by your doctor. Bed-confined is defined as unable to get up from bed without assistance; unable to

Services not covered by Medicare	Not covered under any condition	Covered only under specific condition
		ambulate; and unable to sit in a chair or wheelchair.

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

Chapter 5

Using the plan's coverage for your Part D prescription drugs

Chapter 5. Using the plan's coverage for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the *"Low-Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't receive this insert, please call Customer Service and ask for the "*LIS Rider*." (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 1. Introduction

Section 1.1

This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs).*

In addition to your coverage for Part D drugs, the plan also covers some drugs under the plan's medical benefits. Through its coverage of Medicare A benefits, our plan generally covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Through its coverage of Medicare Part B benefits, our plan covers drugs including certain chemotherapy drugs, certain drug injections you are given during an office visit and drugs you are given at a dialysis facility. Chapter 4 *(Medical Benefits Chart, what is covered and what you pay)* tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay, as well as your benefits and costs for Part B drugs.

Your drugs may be covered by Original Medicare if you are in Medicare hospice. Our plan only covers Medicare Parts A, B and D services and drugs that are unrelated to your terminal prognosis and related conditions and therefore not covered under the Medicare hospice benefit.

For more information, please see Section 9.4 *(What if you're in Medicare-certified hospice).* For information on hospice coverage and Part C, see the hospice section of Chapter 4 *(Medical Benefits Chart, what is covered and what you pay).*

The following sections discuss coverage of your drugs under the plan's Part D benefit rules. Section 9, *Part D drug coverage in special situations* includes more information on your Part D coverage and Original Medicare.

Section 1.2

Basic rules for the plan's Part D drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must have a provider (a doctor, dentist or other prescriber) write your prescription.
- Your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers, the next time you call or visit, if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed.

- You generally must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the *"Drug List"* for short). (See Section 3, *Your drugs need to be on the plan's "Drug List."*)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

Section 2. Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1

To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on the plan's *Drug List*.

Our network includes pharmacies that offer standard cost sharing and pharmacies that offer preferred cost sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost sharing may be less at pharmacies with preferred cost sharing.

Section 2.2

Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (www.anthem.com/ca) or call Customer Service (phone numbers are printed on the back cover of this booklet).

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost sharing rather than a network pharmacy that offers standard cost sharing. The *Provider/ Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. You can find out more about how your out-of-pocket costs could be different for different drugs by contacting us.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or, if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are printed on the back cover of this booklet) or use the *Provider/ Pharmacy Directory*. You can also find information on our website at www.anthem.com/ca.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy. Our plan will cover home infusion therapy if:
  - Your prescription drug is on our plan's formulary or a formulary exception has been granted for your prescription drug.
  - Your prescription drug is not otherwise covered under our plan's medical benefit.
  - Our plan has approved your prescription for home infusion therapy.
  - Your prescription is written by an authorized prescriber.

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

- Pharmacies that supply drugs for residents of a long-term-care (LTC) facility. Usually, a long-term-care (LTC) facility (such as a nursing home) has its own pharmacy. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies, which is typically the pharmacy that the LTC facility uses. If you have any difficutly accessing your Part D benefits in an LTC facility, please contact Customer Service.
- Pharmacies that serve the Indian Health Service/ Tribal/Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination or education on their use. (*Note:* This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider/Pharmacy Directory* or call Customer Service (phone numbers are printed on the back cover of this booklet).

Section 2.3

Using the plan's mail-order services

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, call our mail-order Customer Service at 1-888-565-8361. TTY users should call 711. Hours are 24 hours a day, 7 days a week. Our Interactive Voice Response (IVR) Service is available 24 hours a day, 7 days a week.

Usually a mail-order pharmacy order will get to you in no more than 7-10 days. If for some reason your mail-order prescription is delayed, please contact Customer Service at 1-888-565-8361. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or, if we need to contact the prescribing physician, delivery could take longer.

It is advisable for first-time users of the mail-order pharmacy to ask the doctor for two signed prescriptions:

- One for an initial supply to be filled at their local retail participating pharmacy.
- The second for up to a three-month supply with refills to send to the mail-order pharmacy.

New prescriptions the pharmacy receives directly from your doctor's office:

The pharmacy will automatically fill and deliver new prescriptions it receives from health care providers, without checking with you first, if either:

- You used mail-order services with this plan in the past, or

- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request automatic delivery of all new prescriptions now or at any time by providing consent on your first new home delivery prescription, sent in by your physician.

If you receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling the Customer Service phone number on your membership card.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order, before you are billed and it is shipped. It is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, please contact us by calling the Customer Service phone number on your membership card.

Refills on mail-order prescriptions:

For refills, please contact your pharmacy 21 days before you think the drugs you have on hand will run out to make sure your next order is shipped to you in time.

So the pharmacy can reach you to confirm your order before shipping, please make sure to let the pharmacy know the best ways to contact you by calling the Customer Service phone number on your membership card.

Section 2.4

How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply (also called an "extended supply") of "maintenance" drugs on our plan's *Drug List*. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition. You may order this supply through mail order (see Section 2.3) or you may go to a retail pharmacy.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan's network **mail-order services.** These drugs are marked as **"mail-order" drugs** on our plan's *Drug List*. Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5

When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy.

If you cannot use a network pharmacy, here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- You are traveling within the United States and its territories and become ill, or lose or run out of your prescription drugs.
- The prescription is for a medical emergency or urgent care.
- You are unable to obtain a covered drug in a timely manner within our service area because a network pharmacy that provides 24-hour service is not available within a 25-mile driving distance.
- You are filling a prescription for a covered drug that is not regularly stocked at an accessible network retail pharmacy (for example, an orphan drug or other specialty pharmaceutical).

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby. (Phone numbers for Customer Service are printed on the back cover of this booklet.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

Section 3. Your drugs need to be on the plan's "*Drug List*"

Section 3.1

The "*Drug List*" tells which Part D drugs are covered

The plan has a "*List of Covered Drugs (Formulary).*" In this *Evidence of Coverage*, **we call it the "*Drug List*" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's *Drug List.*

The drugs on the *Drug List* are only those covered under Medicare Part D (earlier in this Chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's *Drug List* as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either:*

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- *-- or --* Supported by certain reference books. (These reference books are: the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor and, for cancer, the National Comprehensive Cancer Network and Clinical Pharmacology or their successors.)

The *Drug List* includes both brand-name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Generally, it works just as well as the brand-name drug and

usually costs less. There are generic drug substitutes available for many brand-name drugs.

What is *not* on the *Drug List*?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our *Drug List*.

Section 3.2

There are six "cost-sharing tiers" for drugs on the *Drug List*

Every drug on the plan's *Drug List* is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Tier 1 includes preferred generic drugs. This is a cost-sharing tier with low copays.
- Tier 2 includes generic drugs.
- Tier 3 includes preferred brand drugs. It may also include some nonpreferred generic drugs that are priced similarly to the original brand drug.
- Tier 4 includes nonpreferred drugs. It may also include some nonpreferred generic drugs that are priced similarly to the original brand drug.
- Tier 5 includes specialty drugs. Drugs in this cost-sharing tier generally cost you more than drugs in other cost-sharing tiers.
- Tier 6 includes select care drugs at no cost on drugs for diabetic, high blood pressure, cholesterol, and osteoporosis conditions.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 *(What you pay for your Part D prescription drugs).*

Section 3.3

How can you find out if a specific drug is on the *Drug List?*

You have three ways to find out:

1. Check the most recent *Drug List* we sent you in the mail.
2. Visit the plan's website (www.anthem.com/ca). The *Drug List* on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's *Drug List* or to ask for a copy of the list. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 4. There are restrictions on coverage for some drugs

Section 4.1

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work just as well medically as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to

make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Please note that sometimes a drug may appear more than once in our *Drug List*. This is because different restrictions or cost sharing may apply based on factors such as the strength, amount or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2

What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. **When a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you or has written "no substitutions" on your prescription for a brand-name drug, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly, but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy."**

Quantity limits

For certain drugs, we limit the amount of the drug that you can have, by limiting how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3

Do any of these restrictions apply to your drugs?

The plan's *Drug List* includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the *Drug List*. For the most up-to-date information, call Customer Service (phone numbers are printed on the back cover of this booklet) or check our website (www.anthem.com/ca).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Customer Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the coverage decision process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9,

Section 6.2 for information about asking for exceptions.)

Section 5. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1

There are things you can do if your drug is not covered in the way you'd like it to be covered

We hope that your drug coverage will work well for you. But it's possible that there could be a prescription drug you are currently taking, or one that you and your provider think you should be taking that is not on our formulary or is on our formulary with restrictions.

For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug. As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you.
- The drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be. The plan puts each covered drug into one of six different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the *Drug List* or, if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2

What can you do if your drug is not on the *Drug List* or, if the drug is restricted in some way?

If your drug is not on the *Drug List,* or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception, and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the *Drug List,* or, when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's *Drug List*.**

- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who are new or who were in the plan last year and aren't in a long-term-care (LTC) facility:** We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you were new and during the first 90 days of the calendar year if you were in the plan last year.** This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy.
- **For those members who are new or who were in the plan last year and reside in a long-term-care (LTC) facility:** We will cover a temporary supply of your drug **during the first 90 days of your membership in the plan if you are new and during the first 90 days of the calendar year if you were in the plan last year.** The total supply will be for a maximum of 98 days. If your prescription is written for fewer days, we allow multiple fills to provide up to a maximum of 98 days of medication. (Please note that the long-term-care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days, reside in a long-term-care (LTC) facility and need a supply right away:** We will cover one 34-day supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above long-term-care transition supply.

To ask for a temporary supply, call Customer Service (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

For example, you can ask the plan to cover a drug even though it is not on the plan's *Drug List*. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3

What can you do if your drug is in a cost-sharing tier you think is too high?

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in the Generic Drugs tier, Nonpreferred Drugs tier or generic drugs in the Preferred Brand Drugs tier, you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our Specialty Drugs tier are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in this tier.

Section 6. What if your coverage changes for one of your drugs?

Section 6.1

The *Drug List* can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make changes to the *Drug List.*

For example, the plan might:

- **Add or remove drugs from the *Drug List.*** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled, and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand-name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's *Drug List.*

Section 6.2

What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the *Drug List.* We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the *Drug List*, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happen for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand-name drug you are taking is replaced by a new generic drug,** the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or you and your provider can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints)).*
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the *Drug List*. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

Section 7. What types of drugs are *not* covered by the plan?

Section 7.1

Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found, upon appeal, to be a drug that is not excluded under Part D, and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and, for cancer, the National Compreshensive Cancer Network and Clinical Pharmacology, or their successors. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra and Caverject
- Drugs when used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

If you receive "Extra Help" paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8. Show your plan membership card when you fill a prescription

Section 8.1

Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose.

When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

Section 8.2

What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can **then ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

Section 9. Part D drug coverage in special situations

Section 9.1

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage. Chapter 6 *(What you pay for your Part D prescription drugs)* gives more information about drug coverage and what you pay.

Please note: When you enter, live in or leave a skilled nursing facility, you are entitled to a Special Enrollment Period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan,* tells

when you can leave our plan and join a different Medicare plan.)

Section 9.2

What if you're a resident in a long-term-care (LTC) facility?

Usually, a long-term-care (LTC) facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term-care (LTC) facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Provider/Pharmacy Directory* to find out if your long-term-care (LTC) facility's pharmacy is part of our network. If it isn't, or, if you need more information, please contact Customer Service (phone numbers are printed on the back cover of this booklet.)

What if you're a resident in a long-term-care (LTC) facility and become a new member of the plan?

If you need a drug that is not on our *Drug List* or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The total supply will be for a maximum of 98 days, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

If you have been a member of the plan for more than 90 days and need a drug that is not on our *Drug List* or, if the plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3

What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator.** He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is **"creditable,"** it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4

What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an antinausea, laxative, pain medication or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this section that tell about the rules for getting drug coverage under Part D, Chapter 6 *(What you pay for your Part D prescription drugs)* gives more information about drug coverage and what you pay.

Section 10. Programs on drug safety and managing medications

Section 10.1

Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis.

During these reviews, we look for potential problems such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 10.2

Medication Therapy Management (MTM) program to help members manage their medications

We have a program that can help our members with complex health needs. For example, some members have several medical conditions, take different drugs at the same time and have high drug costs.

This program is voluntary and free to members. A team of pharmacists and doctors developed the program for us. This program can help make sure that our members get the most benefit from the drugs they take.

Our program is called a Medication Therapy Management (MTM) program. Some members who take medications for different medical conditions may be able to get services through a MTM program. A pharmacist or other health professional will give you

a comprehensive review of all your medications. You can talk about how best to take your medications, your costs and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to have your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists and other health care providers. Also, keep your medication list with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us, and we will withdraw you from the program. If you have any questions about these programs, please contact Customer Service (phone numbers are printed on the back cover of this booklet).

Chapter 6

What you pay for your Part D prescription drugs

Chapter 6. What you pay for your Part D prescription drugs

Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the *"Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs"* (also known as the *"Low-Income Subsidy Rider"* or the *"LIS Rider"*), which tells you about your drug coverage. If you don't receive this insert, please call Customer Service and ask for the "*LIS Rider."* (Phone numbers for Customer Service are printed on the back cover of this booklet.)

Section 1. Introduction

Section 1.1

Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs.

Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary)*:** to keep things simple, we call this the *"Drug List."*
  - This *Drug List* tells which drugs are covered for you.
  - It also tells which of the six "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the *Drug List*, call Customer Service (phone numbers are printed on the back cover of this booklet). You can also find the *Drug List* on our website at www.anthem.com/ca. The *Drug List* on the website is always the most current.
- **Chapter 5 of this booklet:** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan's *Provider/Pharmacy Directory:*** In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Provider/Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

Section 1.2

Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost sharing," and there are three ways you may be asked to pay.

- The **"deductible"** is the amount you must pay for drugs before our plan begins to pay its share.
- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

Section 2. What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1

What are the drug payment stages for Anthem MediBlue Access (PPO) members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled.

Keep in mind, you are always responsible for the plan's monthly premium regardless of the drug payment stage.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly deductible stage During this stage, **you pay the full cost** of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs. You stay in this stage until you have paid $165.00 for your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs. ($165.00 is the amount of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier deductible.) (Details are in Section 4 of this chapter.)	**Initial coverage stage** During this stage, the plan pays its share of the cost of your Tier 1: Preferred Generic and Tier 6: Select Care Drugs drugs, and **you pay your share of the cost.** After you (or others on your behalf) have met your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier deductible, the plan pays its share of the costs of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs, and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments, plus any Part D plan's payments) total $3,700. (Details are in Section 5 of this chapter.)	**Coverage gap stage** During this stage, you pay 40% of the price for brand-name drugs (plus a portion of the dispensing fee) and 51% of the price for generic drugs. You stay in this stage until your year-to-date **"out-of-pocket costs"** (your payments) reach a total of $4,950. This amount and rules for counting costs toward this amount have been set by Medicare. (Details are in Section 6 of this chapter.)	**Catastrophic coverage stage** During this stage, **the plan will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2017). (Details are in Section 7 of this chapter.)

*The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. For more information about the "Extra Help" program, please see Chapter 2, Section 7.

Section 3. We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1

We send you a monthly report called the "*Part D Explanation of Benefits*" (the "*Part D EOB*")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next.

In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket, or others pay on your behalf, plus the amount paid by the plan.

Our plan will prepare a written report called the *Part D Explanation of Benefits* (it is sometimes called the "*Part D EOB*") when you have had one or more prescriptions filled through the plan during the previous month.

It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2

Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies.

Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count

toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive a *Part D Explanation of Benefits* (a *Part D EOB*) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

Section 4. During the deductible stage, you pay the full cost of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs

Section 4.1

You stay in the deductible stage until you have paid $165.00 for your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs

The deductible stage is the first payment stage for your drug coverage. You will pay a yearly deductible of $165.00 on Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs. **You must pay the full cost of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs** until you reach the plan's deductible amount. For all other drugs you will not have to pay any deductible and will start receiving coverage immediately.

- Your **"full cost"** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **"deductible"** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid $165.00 for your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Nonpreferred Drug and Tier 5: Specialty Tier drugs, you leave the deductible stage and move on to the next drug payment stage, which is the initial coverage stage.

Section 5. During the initial coverage stage, the plan pays its share of your drug costs, and you pay your share

Section 5.1

What you pay for a drug depends on the drug and where you fill your prescription

During the initial coverage stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has six cost-sharing tiers

Every drug on the plan's *Drug List* is in one of six cost-sharing tiers. In general, the higher the

cost-sharing tier number, the higher your cost of the drug:

- Tier 1 includes preferred generic drugs. This is a cost-sharing tier with low cost copays.
- Tier 2 includes generic drugs.
- Tier 3 includes preferred brand drugs. It may also include some nonpreferred generic drugs that are priced similarly to the original brand drug.
- Tier 4 includes nonpreferred drugs. It may also include some nonpreferred generic drugs that are priced similarly to the original brand drug.
- Tier 5 includes specialty drugs. Drugs in this cost-sharing tier generally cost you more than drugs in other cost-sharing tiers.
- Tier 6 includes select care drugs at no cost on drugs for diabetic, high blood pressure, cholesterol, and osteoporosis conditions.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List.*

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy that offers standard cost sharing
- A network retail pharmacy that offers preferred cost sharing
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and the plan's *Provider/Pharmacy Directory.*

Generally, we will cover your prescriptions *only* if they are filled at one of our network pharmacies. Some of our network pharmacies also offer preferred cost sharing. You may go to either network pharmacies that offer preferred cost sharing or other network pharmacies that offer standard cost sharing to receive your covered prescription drugs. Your costs may be less at pharmacies that offer preferred cost sharing.

Section 5.2

A table that shows your costs for a *one-month* supply of a drug

During the initial coverage stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply of a covered Part D prescription drug:			
Tier	**Standard retail cost sharing (in-network)** (up to a 30-day supply from network retail pharmacies or up to a 34-day supply at long-term-care (LTC) pharmacies)	**Preferred retail cost sharing (in-network) or mail-order cost sharing** (up to a 30-day supply)	**Out-of-network cost sharing**[1] (up to a 30-day supply)
Tier 1: Preferred Generic	$10.00[2]	$5.00[2]	$10.00[2]
Tier 2: Generic	$15.00[2]	$10.00[2]	$15.00[2]
Tier 3: Preferred Brand	$47.00[2]	$42.00[2]	$47.00[2]
Tier 4: Nonpreferred Drug	$100.00[2]	$95.00[2]	$100.00[2]
Tier 5: Specialty Tier	29%[2]	29%[2]	29%[2]
Tier 6: Select Care Drugs	$0.00[2]	$0.00[2]	$0.00[2]

1 Generally, we only cover drugs filled at out-of-network pharmacies in limited, nonroutine circumstances, when a network pharmacy is not available. If your cost sharing is a set copayment amount rather than a coinsurance (a percentage of the costs), in addition to your copayment at an out-of-network pharmacy, you pay the difference between the actual charge and what we would have paid at a network pharmacy. So amounts you pay may vary at out-of-network pharmacies.
2 The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. For more information about the "Extra Help" program, please see Chapter 2, Section 7.

Section 5.3

If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a prescription drug covers you a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor prescribes less than a full month's supply, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).

- If you are responsible for coinsurance, you pay a *percentage* of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the *amount* you pay will be less.
- If you are responsible for a copayment for the drug, your copay will be based on the number of days

of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copay for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a seven days' supply of the drug, your payment will be $1 per day multiplied by seven days, for a total payment of $7.

Daily cost sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply. You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply of a drug or drugs, if this will help you better plan refill date for different prescriptions so that you can take fewer trips to the pharmacy. The amount you pay will depend upon the days' supply you receive.

Section 5.4

A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription.

A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term, up to a 90-day supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower.*

Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug:			
Tier	**Standard retail cost sharing (in-network)** [1] (up to a 90-day supply)	**Preferred retail cost sharing (in-network)** [1] (up to a 90-day supply)	**Mail-order cost sharing** (up to a 90-day supply)
Tier 1: Preferred Generic	$30.00[2]	$15.00[2]	$15.00[2]
Tier 2: Generic	$45.00[2]	$30.00[2]	$30.00[2]
Tier 3: Preferred Brand	$141.00[2]	$126.00[2]	$126.00[2]
Tier 4: Nonpreferred Drug	$300.00[2]	$285.00[2]	$285.00[2]
Tier 5: Specialty Tier	A long-term supply is not available for drugs in the Specialty Tier.	A long-term supply is not available for drugs in the Specialty Tier.	A long-term supply is not available for drugs in the Specialty Tier.
Tier 6: Select Care Drugs	$0.00[2]	$0.00[2]	$0.00[2]

1 These select pharmacies are indicated in your *Provider/Pharmacy Directory* by an asterisk.

2 The amount you pay will depend on if you qualify for low-income subsidy (LIS), also known as Medicare's "Extra Help" program. For more information about the "Extra Help" program, please see Chapter 2, Section 7.

Section 5.5

You stay in the initial coverage stage until your total drug costs for the year reach $3,700

You stay in the initial coverage stage until the total amount for the prescription drugs you have filled and refilled reaches the **$3,700 limit for the initial coverage stage.**

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What *you* have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The $165.00 you paid when you were in the deductible stage.
  - The total you paid as your share of the cost for your drugs during the initial coverage stage.
- **What the *plan* has paid** as its share of the cost for your drugs during the initial coverage stage. (If you were enrolled in a different Part D plan at any time during 2017, the amount that the plan paid during the initial coverage stage also counts toward your total drug costs.)

The *Part D Explanation of Benefits* (*Part D EOB*) that we send to you will help you keep track of how much you and the plan, as well as any third parties, have spent on your behalf for your drugs during the year. Many people do not reach the $3,700 limit in a year.

We will let you know if you reach this $3,700 amount. If you do reach this amount, you will leave the initial coverage stage and move on to the coverage gap stage.

Section 6. During the coverage gap stage, you receive a discount on brand-name drugs and pay no more than 51% of the costs of generic drugs

Section 6.1

You stay in the coverage gap stage until your out-of-pocket costs reach $4,950

When you are in the coverage gap stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs. You pay 40% of the negotiated price and a portion of the dispensing fee for brand-name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 51% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (49%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand-name drugs and no more than 51% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2017, that amount is $4,950.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,950, you leave the coverage gap stage and move on to the catastrophic coverage stage.

Section 6.2

How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

These payments *are included* in your out-of-pocket costs

When you add up your out-of-pocket costs, you ***can include*** the payments listed below (as long as they are for Part D covered drugs, and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you pay for drugs when you are in any of the following drug payment stages:
  - The deductible stage.
  - The initial coverage stage.
  - The coverage gap stage.
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the catastrophic coverage stage

When you (or those paying on your behalf) have spent a total of $4,950 in out-of-pocket costs within the calendar year, you will move from the coverage gap stage to the catastrophic coverage stage.

These payments *are not included* in your out-of-pocket costs

When you add up your out-of-pocket costs, you are ***not*** **allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from Part D coverage by Medicare.
- Payments made by the plan for your brand or generic drugs while in the coverage gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs, such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, workers' compensation).

Reminder: If any other organization, such as the ones listed above, pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Part D Explanation of Benefits* (*Part D EOB*) report we send to you includes the current amount of your out-of-pocket costs. Section 3 in this chapter tells about this report. When you reach a total of $4,950 in out-of-pocket costs for the year, this report will tell you that you have left the coverage gap stage and have moved on to the catastrophic coverage stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

Section 7. During the catastrophic coverage stage, the plan pays most of the cost for your drugs

Section 7.1

Once you are in the catastrophic coverage stage, you will stay in this stage for the rest of the year

You qualify for the catastrophic coverage stage when your out-of-pocket costs have reached the $4,950 limit for the calendar year. Once you are in the catastrophic coverage stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
  - – *either* – coinsurance of 5% of the cost of the drug
  - – *or* – $3.30 for a generic drug or a drug that is treated like a generic and $8.25 for all other drugs.
- **Our plan pays the rest** of the cost.

Section 8. What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1

Our plan may have separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccine

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself.** The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccine.** (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.

- Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*

2. Where you get the vaccine medication.

3. Who gives you the vaccine?

What you pay at the time you get the Part D vaccination can vary depending on the circumstances.

For example:

- Sometimes when you get your vaccine, you will have to pay the entire cost for both the vaccine medication and for getting the vaccine. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccine, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccine. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the deductible and coverage gap stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy, and you get your vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet *(Asking us to pay our share of a bill you have received for covered medical services or drugs).*
- You will be reimbursed the amount you paid, less your normal copayment for the vaccine (including administration), less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy and then take it to your doctor's office where they give you the vaccine.

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine, less any difference between the amount the doctor charges and what we normally pay. If you get "Extra Help," we will reimburse you for this difference.

Note: When you get the Part D vaccination at your doctor's office (see Situation 2 above), you **do not** have to pay for the entire cost of the vaccine and its administration youself. You have the option of having your provider bill the vendor directly for the cost of the vaccine and its administration. Please talk to your provider about these payment options prior to services being rendered to select the best option for you.

Section 8.2

You may want to call us at Customer Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

Section 9. Do you have to pay the Part D "late-enrollment penalty"?

Section 9.1

What is the Part D "late-enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, you will not pay a late-enrollment penalty.

The late-enrollment penalty is an amount that is added to your Part D premium. You may owe a late-enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The late-enrollment penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

Your late-enrollment penalty is considered part of your plan premium. If you do not pay your late-enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

Section 9.2

How much is the Part D late-enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or, count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then, Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2017, this average premium amount is $35.63.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $35.63, which equals $4.988. This rounds to $5.00. This amount would be added **to the monthly premium for someone with a late-enrollment penalty.**

There are three important things to note about this monthly late-enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

- Third, if you are *under* 65 and currently receiving Medicare benefits, the late-enrollment penalty will reset when you turn 65. After age 65, your late-enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 9.3

In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late-enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this **"creditable drug coverage."** *Please note:*
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2017* Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

Section 9.4

What can you do if you disagree about your late-enrollment penalty?

If you disagree about your late-enrollment penalty, you or your representative can ask for a review of the decision about your late-enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late-enrollment penalty. Call Customer Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your late-enrollment penalty while you're waiting for a review of the decision about your late-enrollment penalty. If you do, you may be disenrolled for failure to pay your plan premiums.

Section 10. Do you have to pay an extra Part D amount because of your income?

Section 10.1

Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare**. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.**

Section 10.2

How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2015 was:	**If you were married but filed a separate tax return and your income in 2015 was:**	**If you filed a joint tax return and your income in 2015 was:**	**This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)**
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$13.30
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$34.20
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$55.20
Greater than $214,000	Greater than $129,000	Greater than $428,000	$76.20

Section 10.3

What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

Section 10.4

What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you *will* be disenrolled from the plan and lose prescription drug coverage.

Chapter 7

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

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

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

Section 1.1

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

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

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

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

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

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

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

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

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

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

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

(Our plan does not allow providers to balance bill you).

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

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

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5 to learn more.)

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information.

However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* has information about how to make an appeal.

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

Section 2.1

How and where to send us your request for payment

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

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

- You don't have to use the form, but it will help us process the information faster.
- Be sure to sign up at (www.anthem.com/ca) and then log in to download a copy of the form (located under Customer Support). You can also call Customer Service and ask for the form. (Phone numbers for Customer Service are printed on the back cover of this booklet.)

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

Anthem Blue Cross Life and Health Insurance Company
P.O. Box 60007
Los Angeles, CA 90060-0007

Mail your request for payment **for Part D prescription drugs,** together with any bills or receipts, to us at this address:

Express Scripts
ATTN: Medicare Part D
P.O. Box 14718
Lexington, KY 40512-4718

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

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

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

Section 3.1

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

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

- If we decide that the medical care or drug is covered, and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2

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

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

For the details on how to make this appeal, go to Chapter 9 of this booklet *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))*. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal."

Then, after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 in Chapter 9.

Section 4. Other situations in which you should save your receipts and send copies to us

Section 4.1

In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the catastrophic coverage stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the deductible stage and coverage gap stage you can buy your drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our *Drug List*.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the catastrophic coverage stage.
- **Please note:** If you are in the deductible stage and coverage gap stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket

costs correctly and may help you qualify for the catastrophic coverage stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer
Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the catastrophic coverage stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the catastrophic coverage stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 8

Your rights and responsibilities

Chapter 8. Your rights and responsibilities

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

Section 1.1

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

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

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in Braille, large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service (phone numbers are printed on the back cover of this booklet).

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Debemos brindarle información de una manera que le sea útil (en idiomas distintos del inglés y en letra grande)

Para que le brindemos información de un modo adecuado para usted, comuníquese con el Servicio de Atención al Cliente. (Los números de teléfono aparecen en la contraportada de este cuadernillo).

Nuestro plan cuenta con personal y servicios de interpretación gratuitos, disponibles para responder las preguntas de los miembros que no hablen inglés. También podemos brindarle información en textos con letras grandes u otros formatos alternativos, si lo necesita. Si usted reúne los requisitos para Medicare por tener una discapacidad, tenemos la obligación de proporcionarle información sobre los beneficios del plan en forma accesible y adecuada para usted. Para que le brindemos información de un modo adecuado para usted, comuníquese con el Servicio de Atención al Cliente. Los números de teléfono aparecen en la contraportada de este cuadernillo.

Si tiene algún inconveniente para obtener información de nuestro plan por problemas relacionados con el idioma o con una discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana e informe que desea presentar un reclamo. Los usuarios de TTY deben llamar al 1-877-486-2048.

Section 1.2

We must treat you with fairness and respect at all times

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

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

If you have a disability and need help with access to care, please call us at Customer Service (phone

numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3

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

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

As a plan member, you have the right to get appointments and covered services from your providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs, and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us

to do this, we will work with your health care provider to decide whether the changes should be made.

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

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

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

Notices of privacy practices

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

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

State notice of privacy practices

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

Your personal information

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

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

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

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

HIPAA notice of privacy practices

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

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

Your protected health information

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

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

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

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

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

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share your explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations, and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit www.anthem.com/ca/privacy for more information.

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

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

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

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

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer

is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

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

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

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

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

Your rights

Under Federal law, you have the right to:

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

How we protect information

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

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

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

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

Potential impact of other applicable laws

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

Contacting you

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

Complaints

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

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

Contact information

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

Copies and changes

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

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

Effective date of this notice

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

Breast reconstruction surgery benefits

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

- Reconstruction of the breast(s) that underwent a covered mastectomy.

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

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

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

Section 1.5

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

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

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

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider/Pharmacy Directory.*
  - For a list of the pharmacies in the plan's network, see the *Provider/Pharmacy Directory*.
  - For more detailed information about our providers or pharmacies, you can call Customer Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.anthem.com/ca.
- **Information about your coverage, and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary).* These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service or Part D drug is not covered for you, or, if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy, or, if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something

is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times and other concerns.)

– If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6

We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

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

Section 1.7

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

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal or make a complaint – **we are required to treat you fairly.**

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

Section 1.8

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

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

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

Is it about something else?

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

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

Section 1.9

How to get more information about your rights

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

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

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

Section 2.1

What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Customer Service to let us know (phone numbers are printed on the back cover of this booklet).
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called **"coordination of benefits"** because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question, and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - You must pay your plan premiums to continue being a member of our plan.
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A, and most plan members must pay a premium for Medicare Part B, to remain a member of the plan.
  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late-enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
  - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Service (phone numbers are printed on the back cover of this booklet).
  - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Customer Service are printed on the back cover of this booklet.

- For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 9

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

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Background

Coverage decisions and appeals

Making complaints

Background

Section 1. Introduction

Section 1.1

What to do if you have a problem or concern

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

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

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

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

Section 1.2

What about the legal terms?

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

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

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

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

Section 2.1

Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP).**

This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare.
Here are two ways to get information directly from Medicare:

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

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

Section 3.1

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

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

To figure out which part of this chapter will help with your specific problem or concern, **START HERE:** **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered and problems related to payment for medical care or prescription drugs.)	
Yes. My problem is about benefits or coverage. Go on to the next section of this chapter, **Section 4: "A guide to the basics of coverage decisions and appeals."**	**No.** My problem is *not* about benefits or coverage. Skip ahead to **Section 10** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, Customer Service or other concerns."**

Coverage decisions and appeals

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

Section 4.1

Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her, or, if your network doctor refers you to a medical specialist.

You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

Making an appeal

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

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

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

Section 4.2

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

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

- **You can call us at Customer Service** (phone numbers are printed on the back cover of this booklet).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).

- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Customer Service (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3

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

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

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** of this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." (*Applies to these services only:* home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

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

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

Section 5.1

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

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

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting, that we previously approved, will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
   - Note: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
     - Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
     - Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
   - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

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

Section 5.2

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

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

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

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

How to request coverage for the medical care you want

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

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

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

- **However, we can take up to 14 more calendar days** if you ask for more time, or, if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

- **A fast coverage decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

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

- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

Deadlines for a "fast" coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 72 hours (or, if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request.**
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
  - If we do not give you our answer within 14 calendar days (or, if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we

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

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

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

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

Section 5.3

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

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

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

What to do

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

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

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

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

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

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

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

Deadlines for a "fast" appeal

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

Deadlines for a "standard" appeal

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

complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

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

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

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

Section 5.4

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

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down, and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3, and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 5.5

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

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs.* Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

We will say yes or no to your request

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

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

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

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

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

Section 6. Your Part D prescription drugs: how to ask for a coverage decision or make an appeal

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

Section 6.1

This section tells you what to do if you have problems getting a Part D drug, or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary),* rules and restrictions on coverage and cost information, see Chapter 5 *(Using the plan's coverage for your Part D*

prescription drugs) and Chapter 6, *(What you pay for your Part D prescription drugs).*

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?	
If you are in this situation:	**This is what you can do:**
Do you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover?	You can ask us to make an exception. (This is a type of coverage decision.) Start with **Section 6.2** of this chapter.
Do you want us to cover a drug on our *Drug List,* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	You can ask us for a coverage decision. Skip ahead to **Section 6.4** of this chapter.
Do you want to ask us to pay you back for a drug you have already received and paid for?	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **Section 6.4** of this chapter.
Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 6.5** of this chapter.

Section 6.2

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request.

Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "*Drug List"* for short.)

Legal Terms Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a **"formulary exception."**

- If we agree to make an exception and cover a drug that is not on the *Drug List*, you will need to pay the cost-sharing amount that applies to drugs in Tier 4: Nonpreferred Drug. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

- The extra rules and restrictions on coverage for certain drugs include:
  - *Being required to use the generic version* of a drug instead of the brand-name drug.
  - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  - *Being required to try a different drug first,* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")
  - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our *Drug List* is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a **"tiering exception."**

- If your drug is a brand-name drug in the Nonpreferred Drug tier (Tier 4), you can ask us to cover it at a lower cost-sharing amount that applies to drugs in the Preferred Brand tier (Tier 3). This would lower your share of the cost for the drug.
- If your drug is a generic drug in the Nonpreferred Drug tier (Tier 4) or in the Preferred Brand tier (Tier 3), you can ask us to cover it at a lower cost-sharing amount that applies to drugs in the Generics tier (Tier 2). This would lower your share of the cost for the drug.

- If your drug is a generic drug in the Generics tier (Tier 2), you can ask us to cover it at a lower cost-sharing amount that applies to drugs in the Preferred Generics tier (Tier 1). This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the Specialty tier (Tier 5).

Section 6.3

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our *Drug List* includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4

Step-by-step: how to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care or Part D prescription drugs.* Or, if you are asking us to pay you back for a drug, go to the section called, *Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received.*
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet:

Asking us to pay our share of a bill you have received for covered medical services or drugs. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.
- **We must accept any written request,** including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision *only* if you are asking for *a drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

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

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
  - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will

give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about a drug you have not yet received

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested:**
  - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5

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

Legal Terms An appeal to the plan about a Part D drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, mail, or our website, for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your medical care or Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal, in writing, or you may call us at the phone number shown in Chapter 2, Section 1** *(How to contact us when you are making an appeal about your medical care or Part D prescription drugs).*
- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include: if you had a serious illness that prevented you from contacting us, or, if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal"

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

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer **within seven calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for "fast" appeal.
  - If we do not give you a decision within seven calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested:**
  - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we receive your appeal.
  - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6

Step-by-step: how to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision, in writing, and explain the reasons for it.

Deadlines for "fast" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal."
- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within seven calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested:**
  - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
  - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision" you have the right to a Level 3 appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down, and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3, and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

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

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

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

Section 7.1

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

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Customer Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.

- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about the quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

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

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

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

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

Section 7.2

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet).
  Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date, *without paying for it,* while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review"

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

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

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

What happens during this review?

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

Section 7.3

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

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

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

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

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

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

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

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

If the review organization says yes

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

If the review organization says no

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

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

- There are three additional levels in the appeals process after Level 2, (for a total of five levels of appeals). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3, and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 7.4

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

You can appeal to us instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to

handle the job of being the Independent Review Organization. Medicare oversees its work.

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3, and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1

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

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

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, *Definitions of important words.*)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words.*)

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

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

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

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

Section 8.2

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

1. You receive a notice in writing. At least two days before our plan is going to stop covering your care, you will receive a notice.

- The written notice tells you the date when we will stop covering the care for you.
- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells how you can request a fast-track appeal.)
The written notice is called the **"Notice of Medicare Non-Coverage."** To get a sample copy, call Customer Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/

2. You must sign the written notice to show that you received it.

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

Section 8.3

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Customer Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal, *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

What happens during this review?

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

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you**. We will stop paying our share of the costs of this care on the date listed on the notice.

- If you decide to keep getting the home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

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

Section 8.4

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

- There are three additional levels of appeals after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on

to Level 3, and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 8.5

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

You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most).

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

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

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

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

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the "Independent Review Organization."** When we do this, it means that

you are *automatically* going on to Level 2 of the appeals process.

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

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

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

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

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you, in writing, what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

- There are three additional levels of appeals after Level 2, for a total of five levels of appeals. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3, and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4 and 5 of the appeals process.

Section 9. Taking your appeal to Level 3 and beyond

Section 9.1

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

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

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

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

Level 3 Appeal

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

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

Level 4 Appeal

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

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

the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

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

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

Section 9.2

Levels of Appeal 3, 4 and 5 for Part D drug appeals

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the administrative law judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal

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

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal

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

- This is the last step of the appeals process.

Making complaints

Section 10. How to make a complaint about quality of care, waiting times, Customer Service, or other concerns

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

Section 10.1

What kinds of problems are handled by the complaint process?

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

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

Complaint	Example
Quality of your medical care	▪ Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	▪ Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	▪ Has someone been rude or disrespectful to you? ▪ Are you unhappy with how our Customer Service has treated you? ▪ Do you feel you are being encouraged to leave the plan?
Waiting times	▪ Are you having trouble getting an appointment, or waiting too long to get it? ▪ Have you been kept waiting too long by doctors, pharmacists or other health professionals? Or by our Customer Service or other staff at the plan? – Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	▪ Are you unhappy with the cleanliness or condition of a clinic, hospital or doctor's office?

Complaint	Example
Information you get from us	▪ Do you believe we have not given you a notice that we are required to give? ▪ Do you think written information we have given you is hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in Sections 4–9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: ▪ If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. ▪ If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. ▪ When a coverage decision we made is reviewed, and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. ▪ When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2

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

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

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

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

Section 10.3

Step-by-step: making a complaint

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

- **Usually, calling Customer Service is the first step**. If there is anything else you need to do, Customer Service will let you know. You can call Customer Service from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30 at 1-877-811-3107 (TTY: 711).
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
  - You or someone you name may file a grievance. The person you name would be your representative. You may name a relative, friend, lawyer, advocate, doctor or anyone else to act for you.
  - If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.
  - A grievance must be filed, either verbally or in writing, within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or, if we justify a need for additional information, and the delay is in your best interest.
  - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or, if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- **Whether you call or write, you should contact Customer Service right away**. The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

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

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

- **If possible, we will answer you right away**. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information, and the delay is in your best interest, or, if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4

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

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

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

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

Section 10.5

You can also tell Medicare about your complaint

You can submit a complaint about Anthem MediBlue Access (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or, if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 10

Ending your membership in the plan

Chapter 10. Ending your membership in the plan

Section 1. Introduction

Section 1.1

This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

Section 2. When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1

You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late-enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's

standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late-enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2

You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3

In certain situations, you can end your membership during a Special Enrollment Period

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples. For the full list you can contact the plan, call Medicare or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.
  - If you are eligible for "Extra Help" with paying for your Medicare prescriptions.
  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term-care hospital.
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.

- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
  - **If you receive "Extra Help" from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late-enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late-enrollment penalty.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4

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

If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2017*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 3. How do you end your membership in our plan?

Section 3.1

Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- *--or--* You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late-enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late-enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
▪ Another Medicare health plan	▪ Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *with* a separate Medicare prescription drug plan	▪ Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
▪ Original Medicare *without* a separate Medicare prescription drug plan – **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late-enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 9 for more information about the late-enrollment penalty.	▪ **Send us a written request to disenroll.** Contact Customer Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). ▪ You can also contact **Medicare,** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. ▪ You will be disenrolled from our plan when your coverage in Original Medicare begins.

Section 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1

Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

Section 5. Our plan must end your membership in the plan in certain situations

Section 5.1

When must we end your membership in the plan?

Our plan must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than 12 months.
  - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Customer Service are printed on the back cover of this booklet.)
  - Go to Chapter 4, Section 2.3 for information on getting care, when you are away from the service area, through our plan's visitor/traveler benefit.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you are required to pay the extra Part D amount because of your income, and you do not pay it, Medicare **will** disenroll you from our plan, and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

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

Section 5.2

We *cannot* ask you to leave our plan for any reason related to your health

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

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3

You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons, in writing, for ending your membership. We must also explain how you can file

a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11

Legal notices

Chapter 11. Legal notices

Section 1. Notice about governing law

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

Section 2. Notice about nondiscrimination

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

Section 3. Notice about Medicare secondary payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Anthem MediBlue Access (PPO), as a Medicare Advantage organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Section 4. Additional legal notices

Collecting member payments

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

You have 36 months from the date the prescription was filled to file a paper claim. This applies to claims you submit, and not to pharmacy or provider filed claims.

In the event that a service is rendered for which you are billed, you have at least 12 months from the date of service to submit such claims to your plan. According to CMS Pub 100-02 Benefit Policy, Chapter 15, Section 40, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they are **not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished.** However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of

beneficiaries and also is excluded from limits on charges for Medicare covered services.

You may submit such claims to:

Anthem Blue Cross Life and Health Insurance Company
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 Anthem Blue Cross Life and Health Insurance Company, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart in Chapter 4.

No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the authorized company officer.

Cessation of operation

In the event of the cessation of operation or dissolution of your plan in the area in which you reside, this *Evidence of Coverage* will be terminated. You will receive notice 90 days before the *Evidence of Coverage* is terminated.

Please note: If the *Evidence of Coverage* terminates, your coverage will also end.

In that event, the company will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, Anthem Blue Cross Life and Health Insurance Company would arrange for you to obtain, without health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles.

Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure, and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitation of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than three years after the service, upon which the legal action is based, was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency or other circumstance beyond the company's control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a non-network provider

instead of a network provider. Your plan will reimburse you up to the amount that would have been covered under this *Evidence of Coverage*.

- Your plan may require written statements from you and the medical personnel who attended you confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

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

This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service at 1-877-811-3107 or, if you are hearing or speech impaired and have a TTY telephone line, 711. The Customer Service department is available from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30. The plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a "living will" or "power of attorney" to give directions in advance about your health care in case you become unable to make your own health care decisions)

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both - to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "advance directive," because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 2 of this booklet tells how to contact your SHIP. SHIPs have different names depending on which state you are in.

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

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

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don’t follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Anthem Blue Cross Life and Health Insurance Company has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, Anthem Blue Cross Life and Health Insurance Company helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf from, or take any legal action against any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.
- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the “made whole” doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident, or incident resulting in personal injury or illness to you, occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate

with us, do whatever is necessary to enable us to exercise our rights and do nothing to prejudice our rights.

- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

Presidential or Gubernatorial emergencies

In the event of a Presidential or Gubernatorial emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, your plan will make the following exceptions to assure adequate care during the emergency:

- Approve services to be furnished at specified noncontracted facilities that are considered a Medicare-certified facility;
- Temporarily reduce cost sharing for plan-approved out-of-network services to the in-network cost-sharing amounts; and
- Waive in full the requirements for a primary physician referral where applicable.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and, if CMS has not indicated an end date to the disaster or emergency, your plan will resume normal operations 30 days from the initial declaration.

When a disaster or emergency is declared, it is specific to a geographic location (ie: county). Your plan will apply the above exceptions only if you reside in the geographic location indicated.

Chapter 12

Definitions of important words

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall, when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services, prescription drugs, payment for services, or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-name drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic coverage stage – The stage in the Part D drug benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,950 on covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

Combined maximum out-of-pocket amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (nonpreferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory

therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Cost sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan's monthly premium.) Cost sharing includes any combination of the following three types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or 3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received. A "daily cost-sharing rate" may apply, when your doctor prescribes less than a full month's supply of certain drugs for you, and you are required to pay a copayment.

Cost-sharing tier – Every drug on the list of covered drugs is in one of six cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Covered drugs – The term we use to mean all of the prescription drugs covered by our plan.

Covered services – The general term we use in this *Evidence of Coverage* to mean all of the health care services and supplies that are covered by our plan.

Creditable prescription drug coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial care – Custodial care is personal care provided in a nursing home, hospice or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Customer Service – A department, within our plan, responsible for answering your questions about your membership, benefits, grievances and appeals. See Chapter 2 for information about how to contact Customer Service.

Daily cost-sharing rate – A "daily cost-sharing rate" may apply, when your doctor prescribes less than a full month's supply of certain drugs for you, and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or **disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable medical equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs or hospital beds.

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

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

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at preferred, lower cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles and coinsurance.

Generic drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

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

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Hospice – An enrollee who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital inpatient stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income-Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are

affected, so most people will not pay a higher premium.

Initial coverage limit – The maximum limit of coverage under the initial coverage stage.

Initial coverage stage – This is the stage before your total drug costs including amounts you have paid and what your plan has paid on your behalf for the year have reached $3,700.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

In-network maximum out-of-pocket amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (nonpreferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term-care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility(ies).

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

Late-enrollment penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, you will not pay a late-enrollment penalty.

List of Covered Drugs **(Formulary or *"Drug List"*)** – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low-Income Subsidy (LIS) – See "Extra Help."

Medicaid (or medical assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically accepted indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically necessary – Services, supplies or drugs that are needed for the prevention, diagnosis or treatment

of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2017.

Medicare Advantage (MA) plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage plans with prescription drug coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with end-stage renal disease (unless certain exceptions apply).

Medicare coverage gap discount program – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the coverage gap stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

Medicare-covered services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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

Medicare prescription drug coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance, sold by private insurance companies, to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them **"network providers"** when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers, or, if the providers agree to provide you

with plan-covered services. Network providers may also be referred to as "plan providers."

Optional supplemental benefits – Non-Medicare covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect optional supplemental benefits in order to get them.

Organization determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("traditional Medicare" or "fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance) and is available everywhere in the United States.

Out-of-network pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this *Evidence of Coverage,* most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-pocket costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

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

Part D – The voluntary Medicare prescription drug benefit program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs). Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred cost sharing – Preferred cost sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) plan – A Preferred Provider Organization plan is a Medicare Advantage plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about primary care providers.

Prior authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

Quantity limits – A management tool that is designed to limit the use of selected drugs for quality, safety or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

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

Service area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled nursing facility (SNF) care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or, if we violate our contract with you.

Special needs plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Standard cost sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Anthem MediBlue Access (PPO) Customer Service – contact information

Call: 1-877-811-3107. Calls to this number are free. From October 1 through February 14, Customer Service representatives will be available to answer your call directly from 8 a.m. to 8 p.m., seven days a week, except Thanksgiving and Christmas. Beginning February 15, Customer Service representatives will be available to answer your call from 8 a.m. to 8 p.m., Monday through Friday, except holidays. Our automated system is available any time for self-service options. You can also leave a message after hours and on weekends and holidays. Please leave your phone number and the other information requested by our automated system. A representative will return your call by the end of the next business day.
Customer Service also has free language interpreter services available for non-English speakers.

TTY: 711. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through February 14, and Monday to Friday (except holidays) from February 15 through September 30.

Fax: 1-877-664-1504

Write: Anthem Blue Cross Life and Health Insurance Company Customer Service
P.O. Box 60007
Los Angeles, CA 90060-0007

Website: www.anthem.com/ca

State Health Insurance Program

State Health Insurance Programs are state programs that get money from the Federal government to give free local health insurance counseling to people with Medicare.

In California:

California Health Insurance Counseling & Advocacy Program (HICAP) – contact information

Call: 1-800-434-0222

TTY: 1-800-735-2929

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

Write: California Health Insurance Counseling & Advocacy Program (HICAP)
1300 National Drive
Suite 200
Sacramento, CA 95834-1992

Website: www.aging.ca.gov/HICAP