Wellpoint Full Dual Advantage (HMO D-SNP) Evidence of Coverage

January 1 – December 31, 2024

Your Health and Drug Coverage under Wellpoint Full Dual Advantage (HMO D-SNP)

Evidence of Coverage Introduction

This *Evidence of Coverage,* otherwise known as the *Member Handbook,* tells you about your coverage under our plan through December 31, 2024. It explains health care services, including behavioral health (mental health and substance use disorder treatment) services, prescription drug coverage, and Managed Long-Term Services and Supports (MLTSS). Key terms and their definitions appear in alphabetical order in **Chapter 12** of your *Evidence of Coverage*.

This is an important legal document. Keep it in a safe place.

When this *Evidence of Coverage* says “we”, “us”, “our”, or “our plan”, it means Wellpoint Full Dual Advantage (HMO D-SNP).

This document is available for free in Spanish.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at the number at the bottom of this page. The call is free.

When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at https://shop.wellpoint.com/medicare.We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-844-765-5160. Someone that speaks Spanish, Chinese, Tagalog, French, Vietnamese, German, Korean, Russian, Arabic, Italian, Portuguese, French Creole, Polish, Hindi and Japanese can help you. This is a free service.

- "نوفر لك خدمات المترجمين الفوريين المجانية للإجابة على أي أسئلة قد تكون لديك حول خطتنا الصحية أو الخاصة بالأدوية. للحصول على مترجم فوري، ما عليك إلا الاتصال بنا على الرقم 1-844-765-5160 (TTY: 711) . ويمكن أن يساعدك شخص يتحدث الإسبانية والصينية والتاغالوغية والفرنسية والفيتنامية والألمانية والكورية والروسية والعربية والإيطالية والبرتغالية والفرنسية الكريولية والبولندية والهندية واليابانية. وهذه الخدمة مجانية."

- « Afin de répondre à toutes vos questions concernant notre régime d'assurance maladie ou d'assurance médicaments, nous vous proposons des services d'interprètes gratuits. Pour obtenir l'aide d'un interprète, veuillez nous appeler au 1-844-765-5160 (TTY: 711). Une personne parlant espagnol, chinois, tagalog, français, vietnamien, allemand, coréen, russe, arabe, italien, portugais, créole français, polonais, hindi et japonais vous assistera. Ce service est gratuit. »
- „Unser kostenloser Dolmetscherservice beantwortet Ihre Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-844-765-5160 (TTY: 711). Man wird Ihnen dort auf Spanisch, Chinesisch, Tagalog, Französisch, Vietnamesisch, Deutsch, Koreanisch, Russisch, Arabisch, Italienisch, Portugiesisch, kreolischem Französisch, Polnisch, Hindi und Japanisch weiterhelfen. Dieser Service ist kostenlos.“
- “Nou gen sèvis entèprèt gratis pou reponn nenpòt kesyon ou ka genyen sou plan sante oswa medikaman nou an. Pou jwenn yon entèprèt jis rele nou nan 1-844-765-5160 (TTY: 711). Yon moun ki pale Panyòl, Chinwa, Tagalog, Fransè, Vyetnamyen, Alman, Koreyen, Ris, Arab, Italyen, Pòtigè, Fransè Kreyòl, Polonè, Hindi ak Japonè ka ede w. Sa a se yon sèvis gratis.”
- "हमारे पास हमारे स्वास्थ्य या दवा योजना के बारे में आपके किसी भी प्रश्न का उत्तर देने के लिए मुफ़्त दुभाषिया सेवाएं हैं। दुभाषिया प्राप्त करने के लिए हमें 1-844-765-5160 (TTY: 711). पर कॉल करें। कोई व्यक्ति जो स्पैनिश, चीनी, तागालोग, फ्रेंच, वियतनामी, जर्मन, कोरियाई, रूसी, अरबी, इतालवी, पुर्तगाली, फ्रेंच क्रियोल, पोलिश, हिंदी और जापानी बोलता है, आपकी मदद कर सकता है। यह एक नि:शुल्क सेवा है।"
- “Disponiamo di un servizio gratuito di interpretariato per rispondere a eventuali dubbi riguardo al nostro piano sanitario o farmaceutico. È possibile ottenere questo servizio contattandoci al numero 1-844-765-5160 (TTY: 711.. Il servizio è disponibile in spagnolo, cinese, tagalog, francese, vietnamita, tedesco, coreano, russo, arabo, italiano, portoghese, creolo francese, polacco, hindi e giapponese. AAll servizio è gratuito.”
- 「弊社では、健康や医薬品に関するどんなご質問にもお答えする無料の通訳サービスをご用意しています。通訳が必要場合は、1-844-765-5160 (TTY: 711).までお電話ください。通訳言語は、スペイン語、中国語、タガログ語、フランス語、ベトナム語、ドイツ語、韓国語、ロシア語、アラビア語、イタリア語、ポルトガル語、ヒンディー語、そして日本語に対応しております。サービスは無料となっております。」
- "저희 건강 플랜이나 약 플랜에 관한 질문에 답해드리기 위해 무료 통역 서비스를 제공해드립니다. 통역사를 이용하시려면 저희에게 1-844-765-5160 (TTY:

711).번으로 전화해 주십시오. 스페인어, 중국어, 타갈로그어, 프랑스어, 베트남어, 독일어, 한국어, 러시아어, 아랍어, 이탈리아어, 포르투갈어, 프랑스 크리올어, 폴란드어, 힌디어, 일본어를 구사하는 사람이 도와드릴 수 있습니다. 서비스 이용은 무료입니다."

- “Oferujemy bezpłatne usługi tłumacza ustnego, który odpowie na wszelkie pytania dotyczące naszego planu zdrowotnego lub lekowego. Aby zamówić tłumacza, wystarczy do nas zadzwonić pod numer 1-844-765-5160 (TTY: 711.. Pomocy może udzielić ktoś, kto mówi po hiszpańsku, chińsku, tagalsku, francusku, wietnamsku, niemiecku, koreańsku, rosyjsku, arabsku, włosku, portugalsku, francusku kreolsku, polsku, hindi lub japońsku. Jest to usługa bezpłatna.”
- "Dispomos de serviços de interpretação para responder a todas as dúvidas que possa ter acerca do nosso plano sobre saúde ou medicamentos. Para obter um intérprete, basta contactar-nos através do número 1-844-765-5160 (TTY: 711). Temos fluentes em espanhol, chinês, tagalo, francês, vietnamita, alemão, coreano, russo, árabe, italiano, português, crioulo de base francesa, polaco, hindi e japonês disponíveis para prestar apoio. Este é um serviço gratuito."
- «Мы можем предоставить вам бесплатные услуги переводчика, чтобы вы могли получить ответы на все ваши вопросы о нашем плане медицинского обслуживания и обеспечения медицинскими препаратами. Чтобы запросить услуги переводчика, звоните по номеру 1-844-765-5160 (TTY: 711). Специалист, владеющий испанским, китайским, тагальским, французским, вьетнамским, немецким, корейским, русским, арабским, итальянским, португальским, франко-креольским, польским, хинди или японским языком, может оказать вам помощь. Данная услуга предоставляется бесплатно».
- "Brindamos servicios gratuitos de intérpretes para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o de medicamentos. Para obtener los servicios de un intérprete, llámenos al 1-844-765-5160 (TTY: 711. Alguien que habla español, chino, tagalo, francés, vietnamita, alemán, coreano, ruso, árabe, italiano, portugués, francés criollo, polaco, hindi y japonés puede ayudarle. Este servicio es gratuito".
- "Mayroon kaming libreng mga serbisyo ng tagasalin upang sagutin ang anumang katanungan mo tungkol sa aming planong pangkalusugan o plano sa gamot. Para makakuha ng tagasalin, tawagan lang kami sa 1-844-765-5160 (TTY: 711). Isang taong nagsasalita ng Espanyol, Intsik, Tagalog, Pranses, Vietnamese, Aleman, Koreano, Ruso, Arabe, Italyano, Portuges, Pranses na Creole, Polako, Hindi at Hapones ang makakatulong sa iyo. Ito ay isang libreng serbisyo.″

- "Chúng tôi có các dịch vụ thông dịch viên miễn phí để trả lời bất kỳ câu hỏi nào mà quý vị có thể có về chương trình sức khỏe hoặc thuốc của chúng tôi. Để có được một thông dịch viên, chỉ cần gọi cho chúng tôi theo số 1-844-765-5160 (TTY: 711). Nhân viên nói được tiếng Tây Ban Nha, tiếng Trung, tiếng Tagalog, tiếng Pháp, tiếng Việt, tiếng Đức, tiếng Hàn, tiếng Nga, tiếng Ả Rập, tiếng Ý, tiếng Bồ Đào Nha, tiếng Pháp Creole, tiếng Ba Lan, tiếng Hindi và tiếng Nhật có thể giúp quý vị. Đây là một dịch vụ miễn phí."
- 「我們免費提供口譯員服務，為您解答您對我們的健康或藥物計劃存在的任何疑問。若需要口譯員，只需致電 1-844-765-5160 (TTY: 711). 聯絡我們即可。講西班牙語、漢語、他加祿語、法語、越南語、德語、韓語、俄語、阿拉伯語、義大利語、葡萄牙語、法式克裡奧爾語、波蘭語、印地語和日語人士可以幫助你。此為免費服務。

Disclaimers

- Wellpoint Full Dual Advantage (HMO D-SNP) is a Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP) with a Medicare contract and a contract with the New Jersey Medicaid program. Enrollment in Wellpoint Full Dual Advantage (HMO D-SNP) depends on contract renewal.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Wellpoint Full Dual Advantage Evidence of Coverage.
- Using opioid medications to treat pain for more than seven days has serious risks like - addiction, overdose, or even death. If your pain continues, talk to your doctor about alternative treatments with less risk. Some choices to ask your doctor about are: Non opioid medications, acupuncture, or physical therapy to see if they are right for you. Find out how your plan covers these options by calling Member Services at 1-844-765-5160 (TTY: 711).
- CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.
- Coverage under Wellpoint Full Dual Advantage (HMO D-SNP) is qualifying health coverage called “minimum essential coverage.” It satisfies the Patient Protection and Affordable Care Act’s (ACA) individual shared responsibility requirement. Visit the Internal Revenue Service (IRS) website at www.irs.gov/Affordable-Care-Act/Individuals-and-Families for more information on the individual shared responsibility requirement.

- When joining this plan:

  1. You must use in-network providers, DME (Durable Medical Equipment) suppliers, and pharmacies.

  2. You will be enrolled automatically into Medicaid (NJ FamilyCare) coverage under our plan, and disenrolled from any Medicaid (NJ FamilyCare) plan you are currently enrolled in. All of your Medicaid-covered services, items, and medications will then be covered under our plan, and you must get them from in-network providers.

  3. You will be enrolled automatically into Part D coverage under our plan, and you will be automatically disenrolled from any other Medicare Part D or creditable coverage plan in which you are currently enrolled.

  4. You must understand and follow our plan's rules on referrals.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Wellpoint Full Dual Advantage (HMO D-SNP), a health plan that covers all of your Medicare and NJ FamilyCare (Medicaid) services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Welcome to our plan

Our plan provides Medicare and NJ FamilyCare (Medicaid) services to individuals who are eligible for both programs. Our plan includes doctors, hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care managers and care teams to help you manage your providers and services. They all work together to provide the care you need.

B. Information about Medicare and NJ FamilyCare (Medicaid)

B1. Medicare

Medicare is the federal health insurance program for:

- people 65 years of age or over,
- some people under age 65 with certain disabilities, **and**
- people with end-stage renal disease (kidney failure).

B2. NJ FamilyCare

NJ FamilyCare is the name of the New Jersey Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. NJ FamilyCare helps people with limited incomes and resources pay for MLTSS and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,
- who is eligible,
- what services are covered, **and**
- the cost for services.

States can decide how to run their programs, as long as they follow the federal rules.

Medicare and the state of New Jersey approved our plan. You can get Medicare and NJ FamilyCare services through our plan as long as:

- we choose to offer the plan, **and**

- Medicare and the state of New Jersey allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and NJ FamilyCare services is not affected.

C. Advantages of our plan

You will now get all your covered Medicare and NJ FamilyCare services from our plan, including prescription drugs. **You do not pay anything to join this health plan.**

We help make your Medicare and Medicaid benefits work better together and work better for you. Some of the advantages include:

- You can work with us for **most** of your health care needs.
- You have a care team that you help put together. Your care team may include yourself, your caregiver, doctors, nurses, counselors, or other health professionals.
- You have access to a care manager. This is a person who works with you, with our plan, and with your care team to help make a care plan.
- You're able to direct your own care with help from your care team and care manager.
- Your care team and care manager work with you to make a care plan designed to meet **your** health needs. The care team helps coordinate the services you need. For example, this means that your care team makes sure:
    - Your doctors know about all the medicines you take so they can make sure you're taking the right medicines and can reduce any side effects that you may have from the medicines.
    - Your test results are shared with all of your doctors and other providers, as appropriate.

D. Our plan's service area

Our service area includes these counties in New Jersey: Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren.

Only people who live in our service area can join our plan.

You cannot stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Evidence of Coverage* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You are eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or are lawfully present in the United States, **and**
- are currently eligible for NJ FamilyCare.

If you lose eligibility but can be expected to regain it within three months then you are still eligible for our plan.

Call Member Services for more information.

F. What to expect when you first join our health plan

When you first join our plan, you get a health risk assessment (HRA) within 90 days before or after your enrollment effective date.

We must complete an HRA for you. This HRA is the basis for developing your care plan. The HRA includes questions to identify your medical, behavioral health, and functional needs.

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail.

We'll send you more information about this HRA.

G. Your care team and care plan

G1. Care team

A care team can help you keep getting the care you need. A care team may include your doctor, a care manager, or other health person that you choose.

A care manager is a person trained to help you manage the care you need. You get a care manager when you enroll in our plan. This person also refers you to other community resources that our plan may not provide and will work with your care team to help coordinate your care. Call us at the numbers at the bottom of the page for more information about your care manager and care team.

G2. Care plan

Your care team works with you to make a care plan. A care plan tells you and your doctors what services you need and how to get them. It includes your medical, behavioral health, and MLTSS or other services.

Your care plan includes:

- your health care goals, **and**
- a timeline for getting the services you need.

Your care team meets with you after your HRA. They ask you about services you need. They also tell you about services you may want to think about getting. Your care plan is created based on your needs and goals. Your care team works with you to update your care plan at least every year.

H. Your monthly costs for Wellpoint Full Dual Advantage (HMO D-SNP)

Our plan has no premium.

H1. Monthly Medicare Part B Premium

Medicaid pays your Medicare Part B premium for you when you are enrolled in this plan.

I. Your *Evidence of Coverage*

Your *Evidence of Coverage* is part of our contract with you. This means that we must follow all rules in this document. If you think we've done something that goes against these rules, you may be able to appeal our decision. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage* or call 1-800-MEDICARE (1-800-633-4227).

You can ask for an *Evidence of Coverage* by calling Member Services at the numbers at the bottom of the page. You can also refer to the *Evidence of Coverage* found on our website at the web address at the bottom of the page.

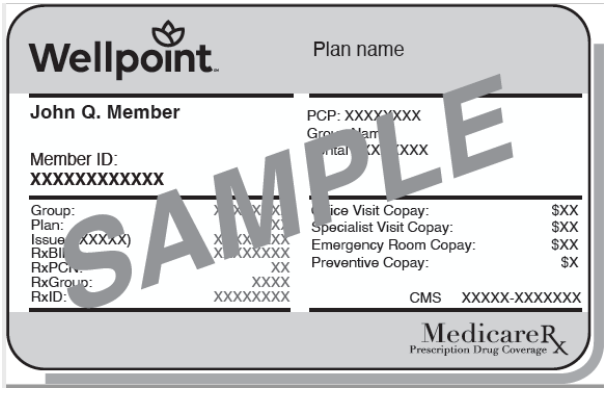
The contract is in effect for the months you are enrolled in our plan between January 1 and December 31.

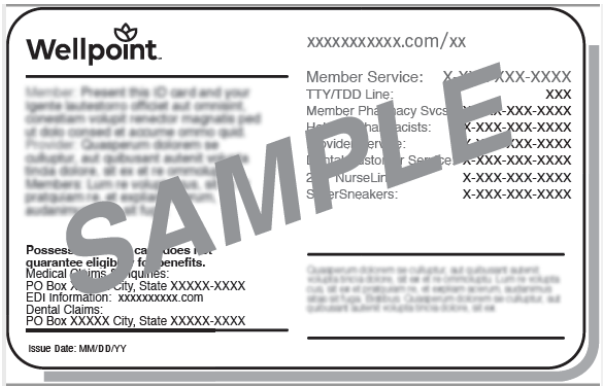
J. Other important information you get from us

Other important information we provide to you includes your Member ID Card, information about how to access a *Provider and Pharmacy Directory*, and information about how to access a *List of Covered Drugs,* also known as a *Formulary*.

J1. Your Member ID Card

Under our plan, you have one card for your Medicare and NJ FamilyCare services, including MLTSS, behavioral health services, and prescriptions. You show this card when you get any services or prescriptions. Here is a sample Member ID Card:





If your Member ID Card is damaged, lost, or stolen, call Member Services at the number at the bottom of the page right away. We will send you a new card.

As long as you are a member of our plan, you do not need to use your red, white, and blue Medicare card or your NJ FamilyCare card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. Refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do if you get a bill from a provider.

J2. *Provider and Pharmacy Directory*

The *Provider and Pharmacy Directory* lists the providers and pharmacies in our plan's network. While you're a member of our plan, you must use network providers to get covered services.

You can ask for a *Provider and Pharmacy Directory* (electronically or in hard copy form) by calling Member Services at the numbers at the bottom of the page. Requests for hard copy Provider and Pharmacy Directories will be mailed to you within three business days. You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

The *Provider and Pharmacy Directory* lists health care professionals (such as doctors, nurse practitioners, and psychologists), facilities (such as hospitals or clinics), and support providers (such as Adult Day Center services and Home Health providers) you may see as a member of our plan. We also list the pharmacies you may use to get your prescription drugs.

Definition of network providers

- Our network providers include:
    - doctors, nurses, and other health care professionals that you can use as a member of our plan;
    - clinics, hospitals, nursing facilities, and other places that provide health services in our plan; **and**
    - MLTSS, behavioral health services, home health agencies, durable medical equipment (DME) suppliers, and others who provide goods and services that you get through Medicare or Medicaid.

Network providers agree to accept payment from our plan for covered services as payment in full.

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.

- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

Call Member Services at the numbers at the bottom of the page for more information. Both Member Services and our website can give you the most up-to-date information about changes in our network pharmacies and providers.

J3. *List of Covered Drugs*

The plan has a *List of Covered Drugs*. We call it the "Drug List" for short. It tells you which prescription drugs our plan covers.

The Drug List also tells you if there are any rules or restrictions on any drugs, such as a limit on the amount you can get. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

Each year, we send you information about how to access the Drug List, but some changes may occur during the year. To get the most up-to-date information about which drugs are covered, call Member Services or visit our website at the address at the bottom of the page.

J4. The *Explanation of Benefits*

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

The EOB tells you the total amount you, or others on your behalf, spent on your Medicare Part D prescription drugs and the total amount we paid for each of your Medicare Part D prescription drugs during the month. This EOB is not a bill. The EOB has more information about the drugs you take. **Chapter 6** of your *Evidence of Coverage* gives more information about the EOB and how it helps you track your drug coverage.

You can also ask for an EOB. To get a copy, contact Member Services at the numbers at the bottom of the page.

K. Keeping your membership record up to date

You can keep your membership record up to date by telling us when your information changes.

We need this information to make sure that we have your correct information in our records. Our network providers and pharmacies also need correct information about you. **They use your membership record to know what services and drugs you get**.

Tell us right away about the following:

- changes to your name, your address, or your phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**
- you take part in a clinical research study. (**Note:** You are not required to tell us about a clinical research study you are in or become part of, but we encourage you to do so.)

If any information changes, call Member Services at the numbers at the bottom of the page.

K1. Privacy of personal health information (PHI)

Information in your membership record may include personal health information (PHI). Federal and state laws require that we keep your PHI private. We protect your PHI. For more details about how we protect your PHI, refer to **Chapter 8** of your *Evidence of Coverage*.

Chapter 2: Important phone numbers and resources

Introduction

This chapter gives you contact information for important resources that can help you answer your questions about our plan and your health care benefits. You can also use this chapter to get information about how to contact your care manager and others to advocate on your behalf. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Member Services

CALL	1-844-765-5160. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. We have free interpreter services for people who do not speak English.
TTY	711 This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
WRITE	Wellpoint Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947
WEBSITE	https://shop.wellpoint.com/medicare

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
    - A coverage decision about your health care is a decision about:
        - your benefits and covered services.
    - Call us if you have questions about a coverage decision about your health care.
    - To learn more about coverage decisions, refer to **Chapter 9** of your *Evidence of Coverage*.

- appeals about your health care
    - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
    - To learn more about making an appeal, refer to **Chapter 9** of your *Evidence of Coverage* or contact Member Services.
- complaints about your health care
    - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section F**).
    - You can call us and explain your complaint at 1-844-765-5160.
    - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to **Section F**).
    - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
    - To learn more about making a complaint about your health care, refer to **Chapter 9** of your *Evidence of Coverage*.
- coverage decisions about your drugs
    - A coverage decision about your drugs is a decision about:
        - your benefits and covered drugs.
    - This applies to your Medicare Part D drugs and NJ FamilyCare covered drugs and over-the-counter drugs.
    - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.
- appeals about your drugs
    - An appeal is a way to ask us to change a coverage decision.

  - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.

- complaints about your drugs
  - You can make a complaint about us or any pharmacy. This includes a complaint about your prescription drugs.
  - If your complaint is about a coverage decision about your prescription drugs, you can make an appeal. (Refer to the section above.)
  - You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
  - For more on making a complaint about your prescription drugs, refer to **Chapter 9** of your *Evidence of Coverage*.
- payment for health care or drugs you already paid for
  - For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of your *Evidence of Coverage*.
  - If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of your *Evidence of Coverage*.

B. Your Care Manager

CALL	1-844-765-5160. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 We have free interpreter services for people who do not speak English.
TTY	711. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30
WRITE	Wellpoint Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947

Contact your care manager to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder treatment) services
- questions about transportation
- questions about Managed Long Term Services and Supports (MLTSS)

C. State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) gives free health insurance counseling to people with Medicare. In New Jersey, the SHIP is called the State Health Insurance Assistance Program (SHIP).

The SHIP is not connected with any insurance company or health plan.

CALL	1-800-792-8820 Monday through Friday 8:30 a.m. to 4:30 p.m.
TTY	711
WRITE	NJ State Health Insurance Assistance Program PO Box 807 Trenton NJ 08625
WEBSITE	www.state.nj.us/humanservices/doas/services/ship/

Contact SHIP for help with:

- questions about Medicare
- SHIP counselors can answer your questions about changing to a new plan and help you:
  - understand your rights,
  - understand your plan choices,
  - make complaints about your health care or treatment, **and**
  - straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Livanta. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Livanta is not connected with our plan.

CALL	1-866-815-5440
TTY	1-866-868-2289 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Livanta LLC BFCC-QIO 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.livantaqio.com/en/states/new_jersey

Contact Livanta for help with:

- questions about your health care rights
- making a complaint about the care you got if you:
  - have a problem with the quality of care,
  - think your hospital stay is ending too soon, **or**
  - think your home health care, skilled nursing facility care, or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

E. Medicare

Medicare is the federal health insurance program for people 65 years of age or over, 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, or CMS.

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov This is the official website for Medicare. It gives you up-to-date information about Medicare. It also has information about hospitals, nursing facilities, doctors, home health agencies, dialysis facilities, inpatient rehabilitation facilities, and hospices. It includes helpful websites and phone numbers. It also has documents you can print right from your computer. If you don't have a computer, your local library or senior center may be able to help you visit this website using their computer. Or, you can call Medicare at the number above and tell them what you are looking for. They will find the information on the website and review the information with you.

F. NJ FamilyCare (Medicaid)

NJ FamilyCare helps with medical and long-term services and supports costs for people with limited incomes and resources.

You are enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call the NJ Department of Human Services, Division of Medical Assistance and Health Services.

Because you are eligible for and enrolled in both Medicare and Medicaid, your coverage through our plan includes coverage for all of the benefits you are entitled to under Medicaid managed care (NJ FamilyCare). As a result, Wellpoint Full Dual Advantage (HMO D-SNP) covers all of your Medicaid benefits, such as hearing aids, routine vision exams, and comprehensive dental services. Additionally, Medicaid pays your Part B premium for you.

CALL	NJ Department of Human Services, Division of Medical Assistance and Health Services 1-800-701-0710 Monday and Thursday 8:00 A.M. - 8:00 P.M.. Tuesday, Wednesday, Friday 8:00 A.M. - 5:00 P.M.
TTY	711
WRITE	NJ Department of Human Services Division of Medical Assistance and Health Services PO Box 712 Trenton, NJ 08625-0712
WEBSITE	www.state.nj.us/humanservices/dmahs/

G. Office of the Insurance Ombudsman

The Office of the Insurance Ombudsman works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The Office of the Insurance Ombudsman also helps you with service or billing problems. They are not connected with our plan or with any insurance company or health plan. Their services are free.

CALL	1-800-446-7467
TTY	711
WRITE	The Office of the Insurance Ombudsman NJ Department of Banking and Insurance PO Box 472 Trenton NJ 08625-0472
WEBSITE	www.state.nj.us/dobi/ombuds.htm

H. New Jersey Office of the State Long-Term Care Ombudsman

The New Jersey Office of the State Long-Term Care Ombudsman helps people get information about nursing homes and resolve problems between nursing homes and residents or their families.

The New Jersey Office of the State Long-Term Care Ombudsman is not connected with our plan or any insurance company or health plan.

CALL	1-877-582-6995
TTY	711
WRITE	NJ Long-Term Care Ombudsman P.O. Box 852 Trenton, NJ 08625-0852
WEBSITE	www.nj.gov/ooie/

I. Programs to Help People Pay for Their Prescription Drugs

The Medicare.gov website (www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, as described below.

I1. Extra Help

Because you are eligible for Medicaid, you qualify for and are getting "Extra Help" from Medicare to pay for your prescription drug plan costs. You do not need to do anything to get this "Extra Help."

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.medicare.gov

J. Social Security

Social Security determines eligibility and handles enrollment for Medicare. U.S Citizens and lawful permanent residents who are 65 and over, or who have a disability or End-Stage Renal Disease (ESRD) and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WRITE	Social Security Administration Office of Public Inquiries and Communications Support 1100 West High Rise 6401 Security Blvd Baltimore, MD 21235
WEBSITE	www.ssa.gov

K. Railroad Retirement Board (RRB)

The RRB is an independent Federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you receive Medicare through the RRB, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the RRB, contact the agency.

CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with a RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1", you may access the automated RRB Help Line and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it. Calls to this number are *not* free.
WEBSITE	www.rrb.gov

L. Group insurance or other insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse's or domestic partner's) employer or retiree group as part of this plan, you way call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. 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 or domestic partner'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 our plan's coverage for your health care and other covered services

Introduction

This chapter has specific terms and rules you need to know to get health care and other covered services with our plan. It also tells you about your care manager, how to get care from different kinds of providers and under certain special circumstances (including from out-of-network providers or pharmacies), what to do if you are billed directly for services we cover, and the rules for owning Durable Medical Equipment (DME). Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Information about services and providers

Services are health care, Managed Long-Term Services and Supports (MLTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and MLTSS are in **Chapter 4** of your *Evidence of Coverage*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Evidence of Coverage.*

Providers are doctors, nurses, and other people who give you services and care. Providers also include hospitals, home health agencies, clinics, and other places that give you health care services, behavioral health services, medical equipment, and certain MLTSS.

Network providers are providers who work with our plan. These providers agree to accept our payment as full payment. Network providers bill us directly for care they give you. When you use a network provider, you usually pay nothing for covered services.

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and NJ FamilyCare. This includes behavioral health and Managed Long Term Services and Supports (MLTSS).

Our plan will generally pay for health care services, behavioral health services, and MLTSS you get when you follow our rules. To be covered by our plan:

- The care you get must be a **plan benefit**. This means we include it in our Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary care provider (PCP)** who orders the care or tells you to use another doctor. As a plan member, you must choose a network provider to be your PCP.
    - You do not need a referral from your PCP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of

care without having a referral from your PCP (for more information, refer to section D1 in this chapter).

- **You must get your care from network providers.** Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you will have to pay the provider in full for the services provided. Here are some cases when this rule does not apply:
  - We cover emergency or urgently needed care from an out-of-network provider (for more information, refer to Section H in this chapter).
  - If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. In this situation, we cover the care at no cost to you.
  - We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. You can get these services at a Medicare-certified dialysis facility.

C. Your care manager

C1. What a care manager is

A care manager is a clinician or other trained person who works for our plan to provide case manager services for you. Care managers partner with patients to get the care they need to be healthy.

A case manager helps patients:

- Understand how their current health is doing
- Create a care plan just for them
- Get the care they need from our plan and their community
- Become part of managing their own health
- Work with health care workers as a team
- Meet their goals of getting healthy

C2. How you can contact your care manager

Contact your care manager by calling Member Services. In many situations, the care manager may provide you with their direct contact information.

C3. How you can change your care manager

If you would prefer to be seen by a different care manager, call Member Services at the number at the bottom of this page to share your concerns and ask for another care manager.

D. Care from providers

D1. Care from a primary care provider (PCP)

You must choose a PCP to provide and manage your care.

Definition of a PCP and what a PCP does do for you

When you join our plan, you must 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. If you do not have a PCP at the time you join, a plan representative can help you select one. If you are not able to choose a PCP, we will assign you to a contracted PCP with a convenient office location based on your home address.

PCPs can be any of the following kinds of doctors as long as they are in our plan's network:

- General practitioners
- Family practitioners
- Internal medicine doctors
- Pediatrics
- Geriatrics

As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a plan member.

You will see your PCP for most of your routine health care needs. There are only a few types of covered services you can get on your own without contacting your PCP first, except, as we explain below and in Section 3.

Your PCP will provide most of your care and will help arrange or coordinate the rest of the covered services you get as a plan member. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions and follow-up care. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP will help arrange your care, such as sending you to see a specialist. In some cases, your PCP will need to get prior authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

When your PCP thinks that you need specialized treatment, he or she may send you to see a plan specialist. A specialist is a doctor who provides health care services for a specific disease or part of the body. Examples of specialists include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint or muscle conditions). The referral from your PCP tells the specialist something about your medical condition and the things that your PCP would like the specialist to check on.

Your PCP is available to coordinate your care with specialists and other providers. If one of your providers orders a service that requires an authorization, the provider is responsible for obtaining a prior authorization from our plan.

Your choice of PCP

You chose a PCP when you completed your enrollment form.

If you did not choose a PCP, we will select one for you who is located close to where you live. Your PCP's name and phone number will be printed on your membership card.

To select a new PCP, you may refer to the Provider and Pharmacy Directory you received, the Provider and Pharmacy Directory on our website, or call the Member Services phone number at the number at the bottom of this page. 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.

If there is a particular specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. Member Services also can help you choose a doctor. If you are already seeing a doctor, you can look in the *Provider and Pharmacy Directory* to see if that doctor is in our network. If so, you can tell us you want to keep that doctor.

Option to change your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP may leave our plan's network. If your PCP leaves our network, we can help you find a new PCP in our network.

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 1st of the following month.

If you want to change your PCP, look for another primary care provider in the plan *Provider and Pharmacy Directory* included with your enrollment materials. If you would like help in choosing a PCP, our Member Services staff can provide you with information to help you decide. To change your PCP, call Member Services at the number shown at the number at the bottom of this page. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment).

Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is able to accept new patients.

Member Services will change your membership record to show the name of your new PCP and tell you when the change to your PCP will take effect. Once your PCP has been changed, you will get a new membership card in the mail within 10 calendar days.

Under certain circumstances, you may continue receiving covered services from a participating physician or other health care professional who has left the network for up to four months beyond the effective date of termination (the end of the notice period).

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- Pregnancy - up to the postpartum evaluation (up to six weeks after delivery).
- Postoperative follow-up care (up to six months).
- Oncological treatment (up to one year).
- Psychiatric treatment (up to one year).

Services you can get without approval from your PCP

In most cases, you need approval from your PCP before using other providers. This approval is called a **referral**. You can get services like the ones listed below without getting approval from your PCP first:

- emergency services from network providers or out-of-network providers
- urgently needed care from network providers
- urgently needed care from out-of-network providers when you can't get to a network provider (for example, if you're outside our plan's service area or during the weekend)

Note: Urgently needed care must be immediately needed and medically necessary.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're outside our plan's service area. Call Member Services before you leave the service area. We can help you get dialysis while you're away.
- Flu shots and COVID-19 vaccinations as well as hepatitis B vaccinations and pneumonia vaccinations.
- Routine women's health care and family planning services. This includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams.
- Additionally, if eligible to get services from Indian health providers, you may use these providers without a referral.

D2. Care from specialists and other network providers

A specialist is a doctor who provides health care for a specific disease or part of the body. There are many kinds of specialists, such as:

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

If you need specialist care, you do not need a referral.

Prior authorization may be required for some services. Prior authorization means approval in advance to get services or certain drugs. Please speak to your provider to obtain prior authorization. The Benefits Chart in Chapter 4 gives information about which services require prior authorization.

D3. When a provider leaves our plan

A network provider you use may leave our plan. If one of your providers leaves our plan, you have certain rights and protections that are summarized below:

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- Under certain circumstances, you may continue receiving covered services from a provider who has left our network for up to four months beyond the effective date of termination (the end of the notice period).
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to ask, and we work with you to ensure, that the medically necessary treatment or therapies you are getting continues. If you are undergoing certain courses of treatment, you may be able to receive longer periods of care as indicated below:
    - Pregnancy: up to the postpartum evaluation -- up to six weeks after delivery.
    - Post-operative follow-up care (care given after surgery): (up to six months).
    - Oncological treatment (treatment for cancer): up to one year.

  - Psychiatric treatment (mental health treatment with a psychiatrist): up to one year.

- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the QIO, a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)

Under certain circumstances, for up to four months beyond the effective date of termination (the end of the notice period), you may continue receiving covered services from a provider who has left our network.

Additionally, if you are undergoing certain courses of treatment, you may receive longer periods of care as indicated below:

- pregnancy – up to the postpartum evaluation (up to six weeks after delivery)
- post-operative follow-up care (up to six months)
- oncological treatment (up to one year)
- psychiatric treatment (up to one year)

If you find out one of your providers is leaving our plan, contact us. We can assist you in finding a new provider and managing your care. Contact Member Services at **1-844-765-5160** (TTY: **711**), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

D4. Out-of-network providers

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or NJ FamilyCare.

- We cannot pay a provider who is not eligible to participate in Medicare and/or NJ FamilyCare.

- If you use a provider who is not eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they are not eligible to participate in Medicare.

E. Managed Long-term services and supports (MLTSS)

The MLTSS program provides home- and community-based services for members that require the level of care typically provided in a nursing facility, and allows them to receive necessary care in a residential or community setting.

Managed long term support services are available to members that qualify. To see if these services may be right for you, please contact your Care manager at 1-844-765-5160 (TTY: 711). You can also find more information in the Benefits Chart in Chapter 4.

F. Behavioral health (mental health and substance use disorder treatment) services

This plan provides coverage for behavioral health services. You may need approval in advance for these services. To see if these services may be right for you, please contact your Care Manager at 1-844-765-5160 (TTY: 711).

G. How to get self-directed care through the Personal Preference Program (PPP)

G1. What self-directed care is

Self-directed care is commonly referred to as PPP. It is an alternate way for individuals to receive their NJ Family Care personal care assistance (PCA) services in the home. This is another option available in the place of having a home health worker hired by an agency to provide care.

You can choose to hire a person(s) of choice to provide care: This includes relatives, friends, and neighbors. You have flexibility and control over the services and when they are provided.

G2. Who can get self-directed care

- You must require assistance with activities of daily living (ADL's) in order to be eligible for PCA Agency services or PPP.

Clinical eligibility is determined by completion of an assessment tool by a nurse.

G3. How to get help in employing personal care providers

To get help employing personal care providers, please contact Member Services at 1-844-765-5160 or 1-855-661-1996 (TTY: 711).

H. Transportation services

If you are in need of emergency transportation, please dial 911. The plan provides coverage for ambulance services include fixed wing, rotary wing, and ground ambulance services associated with a medical emergency.

Nonemergency medical transportation, such as mobile assistance vehicles (MAVs); nonemergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage), are covered directly by Medicaid Fee-for-Service.

All nonemergency medical transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare at 1-866-527-9933. You can also ask your PCP or Care Manager to help you to arrange this service.

Transportation: Nonhealth related

This plan provides 24 one-way transportation trips to grocery stores, SilverSneakers classes, religious services, community centers, banks and Medicare or other government offices (including DMV). To schedule transportation please call 1-866-483-9523. Please call Customer Service for more information at 1-844-765-5160.

I. Covered services in a medical emergency, when urgently needed, or during a disaster

I1. Care in a medical emergency

A medical emergency is a medical condition with symptoms such as severe pain or serious injury. The condition is so serious that, if it doesn't get immediate medical attention, you or anyone with an average knowledge of health and medicine could expect it to result in:

- serious risk to your health or to that of your unborn child; **or**
- serious harm to bodily functions; **or**

- serious dysfunction of any bodily organ or part; **or**
- in the case of a pregnant woman in active labor, when:
  - There is not enough time to safely transfer you to another hospital before delivery.
  - A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You do **not** need approval or a referral from your PCP. You do not need to use a network provider. You may get emergency medical care whenever you need it, anywhere in the U.S. or its territories, from any provider with an appropriate state license.
- **As soon as possible, tell our plan about your emergency.** We 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 Member Services at the number on the back of your plan membership card.

Covered services in a medical emergency

Medicare does not provide coverage for emergency medical care outside the United States and its territories.

If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage.*

The providers who give you emergency care decide when your condition is stable and the medical emergency is over. They will continue to treat you and will contact us to make plans if you need follow-up care to get better.

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Getting emergency care if it wasn't an emergency

Sometimes it can be hard to know if you have a medical or behavioral health emergency. You may go in for emergency care and the doctor says it wasn't really an emergency. As long as you reasonably thought your health was in serious danger, we cover your care.

After the doctor says it wasn't an emergency, we cover your additional care only if:

- You use a network provider **or**
- The additional care you get is considered "urgently needed care" and you follow the rules for getting it. Refer to the next section.

I2. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or a severe sore throat that occurs over the weekend and need treatment.

Urgently needed care in our plan's service area

In most cases, we cover urgently needed care only if:

- You get this care from a network provider **and**
- You follow the rules described in this chapter.

If it is not possible or reasonable to get to a network provider, we cover urgently needed care you get from an out-of-network provider.

You can receive care from any urgent care provider included in your *Provider and Pharmacy Directory.* If you are having trouble finding an urgent care provider, please call Member Services at the number on the bottom of the page.

Urgently needed care outside our plan's service area

When you're outside our plan's service area, you may not be able to get care from a network provider. In that case, our plan covers urgently needed care you get from any provider.

Our plan covers your follow-up care. If you get your urgently needed care from out-of-network providers, we will try to get network providers to take over your care as soon as possible.

Our plan covers worldwide *emergency and urgently needed care* services outside the United States under the following circumstances:

- If you're traveling outside of the United States for less than six months.
- Coverage is limited to $100,000 per year for worldwide emergency services.

This is a supplemental benefit. It's not covered by the Federal Medicare program. You must pay all costs over $100,000 and all costs to return to your service area. You may be able to buy added travel insurance through an authorized agency. $0 copay for each covered worldwide urgently needed service. If you need urgent care outside the United States or its territories, please call Member Services.

I3. 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 our plan.

Visit our website for information on how to get care you need during a declared disaster: https://shop.wellpoint.com/medicare.

During a declared disaster, if you can't use a network provider, you can get care from out-of-network providers at no cost to you. If you can't use a network pharmacy during a declared disaster, you can fill your prescription drugs at an out-of-network pharmacy. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

J. What to do if you are billed directly for services our plan covers

If a provider sends you a bill instead of sending it to our plan, you should ask us to pay the bill.

You should not pay the bill yourself. If you do, we may not be able to pay you back.

If you paid for your covered services or if you got a bill for covered medical services, refer to **Chapter 7** of your *Evidence of Coverage* to find out what to do.

J1. What to do if our plan does not cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of your *Evidence of Coverage*), **and**

- that you get by following plan rules.

If you get services that our plan does not cover, **you pay the full cost yourself**.

If you want to know if we pay for any medical service or care, you have the right to ask us. You also have the right to ask for this in writing. If we say we will not pay for your services, you have the right to appeal our decision.

Chapter 9 of your *Evidence of Coverage* explains what to do if you want us to cover a medical service or item. It also tells you how to appeal our coverage decision. Call Member Services to learn more about your appeal rights.

We pay for some services up to a certain limit. If you go over the limit, you pay the full cost to get more of that type of service. Refer to **Chapter 4** for specific benefit limits. Call Member Services to find out what the benefit limits are and how much of your benefits you've used.

K. Coverage of health care services in a clinical research study

K1. Definition of a clinical research study

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study.

Once Medicare approves a study you want to be in, and you express interest, someone who works on the study contacts you. That person tells you about the study and finds out if you qualify to be in it. You can be in the study as long as you meet the required conditions. You must understand and accept what you must do in the study.

While you're in the study, you may stay enrolled in our plan. That way, our plan continues to cover you for services and care not related to the study.

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

We encourage you to tell us before you take part in a clinical research study.

If you plan to be in a clinical research study, covered for enrollees by Original Medicare, we encourage you or your care manager to contact Member Services to let us know you will take part in a clinical trial.

K2. Payment for services when you are in a clinical research study

If you volunteer for a clinical research study that Medicare approves, you pay nothing for the services covered under the study. Medicare pays for services covered under the study as well as routine costs associated with your care. Once you join a Medicare-approved clinical research study, you're covered for most services and items you get as part of the study. This includes:

- 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 that is part of the research study
- treatment of any side effects and complications of the new care

If you're part of a study that Medicare has **not** approved, you pay any costs for being in the study.

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

L. How your health care services are covered in a religious non-medical health care institution

L1. Definition of a religious non-medical health care institution

A religious non-medical health care institution is a place that provides care you would normally get in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against your religious beliefs, we cover care in a religious non-medical health care institution.

This benefit is only for Medicare Part A inpatient services (non-medical health care services).

L2. Care from a religious non-medical health care institution

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

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

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

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

Medicare Inpatient Hospital coverage limits apply. For more information, please see the Benefits Chart in Chapter 4.

M. Durable medical equipment (DME)

M1. DME as a member of our plan

DME includes certain medically necessary items ordered by a provider, such as wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, intravenous (IV) infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

You always own certain items, such as prosthetics.

In this section, we discuss DME you rent. As a member of our plan, you usually will **not** own DME, no matter how long you rent it.

In certain limited situations, we transfer ownership of the DME item to you. Call Member Services to find out about requirements you must meet and papers you need to provide.

Even if you had DME for up to 12 months in a row under Medicare before you joined our plan, you will **not** own the equipment.

M2. DME ownership if you switch to Original Medicare

In the Original Medicare program, people who rent certain types of DME own it after 13 months. In a Medicare Advantage (MA) plan, the plan can set the number of months people must rent certain types of DME before they own it.

Note: You can find definitions of Original Medicare and MA Plans in Chapter 12. You can also find more information about them in the *Medicare & You 2024* handbook. If you don't have a copy of this booklet, you can get it at the Medicare website (www.medicare.gov/medicare-and-you) 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.

You will have to make 13 payments in a row under Original Medicare, or you will have to make the number of payments in a row set by the MA plan, to own the DME item if:

- you did not become the owner of the DME item while you were in our plan, **and**
- you leave our plan and get your Medicare benefits outside of any health plan in the Original Medicare program or an MA plan.

If you made payments for the DME item under Original Medicare or an MA plan before you joined our plan, **those Original Medicare or MA plan payments do not count toward the payments you need to make after leaving our plan**.

- You will have to make 13 new payments in a row under Original Medicare or a number of new payments in a row set by the MA plan to own the DME item.
    - There are no exceptions to this when you return to Original Medicare or an MA plan.

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare and you're a member of our plan, we cover:

- rental of oxygen equipment
- delivery of oxygen and oxygen contents
- tubing and related accessories for the delivery of oxygen and oxygen contents
- maintenance and repairs of oxygen equipment

Oxygen equipment must be returned when it's no longer medically necessary for you or if you leave our plan.

M4. Oxygen equipment when you switch to Original Medicare or another Medicare Advantage (MA) plan

When oxygen equipment is medically necessary and **you leave our plan and switch to Original Medicare**, you rent it from a supplier for 36 months. Your monthly rental payments cover the oxygen equipment and the supplies and services listed above.

If oxygen equipment is medically necessary **after you rent it for 36 months**, your supplier must provide:

- oxygen equipment, supplies, and services for another 24 months
- oxygen equipment and supplies for up to 5 years if medically necessary

If oxygen equipment is still medically necessary **at the end of the 5-year period**:

- Your supplier no longer has to provide it, and you may choose to get replacement equipment from any supplier.
- A new 5-year period begins.
- You rent from a supplier for 36 months.
- Your supplier then provides the oxygen equipment, supplies, and services for another 24 months.
- A new cycle begins every 5 years as long as oxygen equipment is medically necessary.

When oxygen equipment is medically necessary and **you leave our plan and switch to another MA plan**, the plan will cover at least what Original Medicare covers. You can ask your new MA plan what oxygen equipment and supplies it covers and what your costs will be.

Chapter 4: Benefits chart

Introduction

This chapter tells you about the services our plan covers and any restrictions or limits on those services. It also tells you about benefits not covered under our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Your covered services

This chapter tells you about services our plan covers. You can also learn about services that are not covered. Information about drug benefits is in **Chapter 5** of your *Evidence of Coverage*. This chapter also explains limits on some services.

Because you get assistance from NJ FamilyCare, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of your *Evidence of Coverage* for details about the plan's rules.

If you need help understanding what services are covered, call your care manager *and/or* Member Services at 1-844-765-5160.

B. Rules against providers charging you for services

We don't allow our providers to bill you for in network covered services. We pay our providers directly, and we protect you from any charges. This is true even if we pay the provider less than the provider charges for a service.

You should never get a bill from a provider for covered services. If you do, refer to **Chapter 7** of your *Evidence of Coverage* or call Member Services.

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. It lists covered services in alphabetical order and explains them.

We pay for the services listed in the Benefits Chart when the following rules are met. You do **not** pay anything for the services listed in the Benefits Chart, as long as you meet the requirements described below.

- We provide covered Medicare and NJ FamilyCare covered services according to the rules set by Medicare and NJ FamilyCare.
- The services (including medical care, behavioral health and substance use disorder treatment services, Managed Long Term Services and Supports (MLTSS), supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It

also means the services, supplies, or drugs meet accepted standards of medical practice.

- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you receive from an out-of-network provider will not be covered unless it is an emergency or urgently needed care or unless your plan or a network provider has given you a referral. **Chapter 3** of your *Evidence of Coverage* has more information about using network and out-of-network providers.
- You have a primary care provider (PCP) or a care team that is providing and managing your care.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with a note.

Important Benefit Information for all Members Participating in Wellness and Health Care Planning (WHP) Services

- Because Wellpoint Full Dual Advantage (HMO D-SNP) participates in Value-Based Insurance Design Benefits*,* you will be eligible for the following WHP services, including advance care planning (ACP) services:
    - As a Wellpoint Full Dual Advantage (HMO D-SNP) member, you have access to an online advance care planning resource called, MyDirectives®. This resource helps you to create an advance directive where you can combine the elements of a:
        - Living will– decisions on what medical treatments you would or would not like to receive
        - Medical power of attorney – designation of one or more healthcare agents who can make medical decisions for you if you are not able to
        - Organ donation form
        - And more, including religious preference statements
    - You can create a new digital care plan on MyDirectives® or, if you already have these documents prepared, you can upload them so that they can be more easily shared with those that may need access to it. MyDirectives® is

available to you and your designated medical providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change.

- To get started, log into your Wellpoint Full Dual Advantage (HMO D-SNP) member portal and go to the Programs Dashboard and select Advance Directive Programs. It will take you to MyDirectives® to create a new account, or link your existing account.
- Participation in any programs that include Wellness and Healthcare Planning or Advance Care Planning are voluntary and you are free to decline the services at any time.

- You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.
- **Important Benefit Information for Members with Certain Chronic Conditions.** If you have the following chronic condition(s) and meet certain medical criteria, you may be eligible for additional benefits:
    - Chronic alcohol and other drug dependence;
    - Autoimmune disorders limited to:
        - Polyarteritis nodosa,
        - Polymyalgia rheumatica,
        - Polymyositis,
        - Rheumatoid arthritis, and
        - Systemic lupus erythematosus;
        - Scleroderma
    - Cancer, excluding pre-cancer conditions or in situ status;
    - Cardiovascular disorders limited to:
        - Cardiac arrhythmias,
        - Coronary artery disease,

- Peripheral vascular disease, and
- Chronic venous thromboembolic disorder;

- Chronic heart failure
- Ischemic heart disease
- Hypertension
- Dementia;
  - Alzheimer's
- Diabetes mellitus;
  - Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C: 5.7-6.4%)
- End-stage liver disease;
- End-stage renal disease (ESRD) requiring dialysis;
- Severe hematologic disorders limited to:
  - Aplastic anemia,
  - Hemophilia,
  - Immune thrombocytopenic purpura,
  - Myelodysplatic syndrome,
  - Sickle-cell disease (excluding sickle-cell trait)
- HIV/AIDS;
- Chronic lung disorders limited to:
  - Asthma,
  - Chronic bronchitis,
  - Emphysema,
  - Pulmonary fibrosis, and

- Pulmonary hypertension;
- Chronic Obstructive Pulmonary Disease (COPD)
- Cystic Fibrosis

- Chronic and disabling mental health conditions limited to:
  - Bipolar disorders,
  - Major depressive disorders,
  - Paranoid disorder,
  - Schizophrenia,
  - Schizoaffective disorder
- Neurologic disorders limited to:
- Amyotrophic lateral sclerosis (ALS),
  - Epilepsy,
  - Extensive paralysis (i.e., hemiplegia, quadriplegia, paraplegia, monoplegia),
  - Huntington’s disease,
  - Multiple sclerosis,
  - Parkinson’s disease,
  - Polyneuropathy,
  - Spinal stenosis,
  - Stroke-related neurologic deficit
- Stroke
- Cerebal Palsy
- Can Traumatic brain injury
- Obesity (BMI is greater than or equal to 30)

- Crohn's disease
- Ankylosing spondylitis
- Osteoarthritis
- Osteoporosis
- Chronic back pain
- Blindness

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

- Your request for these benefits will be reviewed to confirm your eligibility and that you are meeting the criteria. If eligible, the benefit(s) will be approved and you will be provided instructions on how to receive the benefit(s).
- Please contact us to find out exactly which benefits you may be eligible for.
- Refer to the "Help with certain chronic conditions" row in the Benefits Chart for more information.
- You do not pay anything for the services listed in the Benefits Chart, as long as you meet the coverage requirements described above.
- All preventive services are free. You will find this apple 🍎 next to preventive services in the Benefits Chart.

D. Our plan's Benefits Chart

Prior authorization may be required for non-preventive services.

Services that our plan pays for		
🍎	**Abdominal aortic aneurysm screening** We pay for a one-time ultrasound screening 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.	
	Acupuncture We pay for acupuncture visits if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; **and** • not associated with pregnancy. Acupuncture treatments must be stopped if you don't get better or if you get worse.	

	Advance directives program[1] As a Wellpoint Full Dual Advantage (HMO D-SNP) member, you have access to an online advance care planning resource called, MyDirectives®. This resource helps you to create an advance directive where you can combine the elements of a: • Living will - decisions on what medical treatments you would or would not like to receive • Medical power of attorney - designation of one or more healthcare agents who can make medical decisions for you if you are not able to • Organ donation form • And more, including religious preferences statements You can create a new digital care plan on MyDirectives® or, if you already have these documents prepared, you can upload them so that they can be more easily shared with those that may need access to it. MyDirectives® is available to you and your designated medical providers 24 hours a day, seven days a week. You can add new information at any time as your health status or wishes change. To get started, log into your Wellpoint Full Dual Advantage (HMO D-SNP) member portal at https://shop.amerigroup.com/medicare. Select "My Plans" from the top menu, then select "Medical" and this will take you to your medical benefits, where you can scroll down to Advance Directive Programs. The link in the benefit detail will take you to MyDirectives® to create a new account, or link your existing account. Participation in any programs that include Wellness and Healthcare Planning or Advance Care Planning are voluntary and you are free to decline the services at any time. [1]Value-Based Insurance Design benefit	

Services that our plan pays for		
	Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	
	Ambulance services Covered ambulance services include ground and air (airplane and helicopter), and ambulance services The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that are not emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health.	**I**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. Contact Member Services for details.
	Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your **Welcome to Medicare** visit. However, you don't need to have had a **Wecome to Medicare** visit to get annual wellness visits after you've had Part B for 12 months.	

Services that our plan pays for		
	Annual routine physical exam In addition to the “Welcome to Medicare” exam or the annual wellness visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases.	
	Autism Spectrum Disorder Services For all members with an Autism Spectrum Disorder (ASD) diagnosis, we pay for: • Applied Behavioral Analysis (ABA) • augmentative and alternative communication services and devices • Sensory Integration (SI) services • allied health services (physical therapy, occupational therapy and speech therapy) • Developmental, Individual-differences, and Relationship-based (DIR) services, including but not limited to DIR Floortime and the Greenspan approach therapy	
	Birthing center Wellpoint covers centers for labor, delivery and immediate postpartum care.	
	Blood and blood products Wellpoint covers whole blood and derivatives, as well as necessary processing and administration costs. Coverage is unlimited (no limit on volume or number of blood products). Coverage begins with the first pint of blood.	

Services that our plan pays for		
	Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	
	Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women age 40 and over • clinical breast exams once every 12 months • one screening mammogram every year for those with a family history of breast cancer or other risk factors. • Additional screenings are available if medically necessary	
	Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's prior authorization. We also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs.	Talk to your provider and get prior authorization.

Services that our plan pays for		
	Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, **and/or** • give you tips to make sure you are eating well.	
	Cardiovascular (heart) disease testing We pay for blood tests to check for cardiovascular disease annually for all members 20 years of age or older, and more frequently if medically necessary. These blood tests also check for defects due to high risk of heart disease.	
	Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 12 months	

Services that our plan pays for		
	Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment • clinical laboratory services • certain medical supplies • durable medical equipment • prefabricated orthoses • physical therapy services • diagnostic radiological services when they are prescribed by a chiropractor within their scope of practice	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.
	Clinical trials Wellpoint covers services such as physician visits and tests beyond Medicare limits. Please see Chapter 3 for more information on how clinical trials are covered.	

Services that our plan pays for	
Colorectal cancer screening We pay for the following services: • Colonscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Blood-based Biomarker Tests for pateints 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • Barium Enema as an alternative to colonoscopy for patients at high risk and 24 months since the last screening barium enema or the last screening colonoscopy. • Barium Enema as an alternative to flexible sigmoidoscopy for patients not at high risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. As of January 1, 2023, colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test resturns a positive result.	

	Dental services This benefit includes diagnostic, preventive, restorative, endodontic, periodontal, prosthetic, oral and maxillofacial surgical services, as well as other adjunctive general services. We pay for dental examinations, cleanings, fluoride treatment and any necessary x-rays. We pay for this service twice per rolling year. Examples of covered services include (but are not limited to): • oral evaluations (examinations) • x-rays and other diagnostic imaging • dental cleaning (prophylaxis) • topical fluoride treatments • fillings • crowns • root canal therapy • scaling and root planing • complete and partial dentures • oral surgical procedures (to include extractions) • intravenous anesthesia/sedation (where medically necessary for oral surgical procedures) Additional diagnostic, preventive and designated periodontal procedures can be considered for members with special health care needs. Some procedures may require prior authorization with documentation of medical necessity, including: • Orthodontic services for members up to age 21 with adequate documentation of a handicapping malocclusion or medical necessity. • Dental treatment in an operating room or ambulatory surgical center. We pay for some dental services when the service is an integral part of specific treatment of a beneficiary's primary medical **This benefit is continued on the next page**	Seek care from your dentist. He or she will arrange your care directly with the plan. If you need help finding a dentist or dental specialist, call 1-833-276-0848.

Services that our plan pays for		
	Dental services (continued) condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.	
	Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	
	Diabetes screening We pay for 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 • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. Depending on the test results, you may qualify for up to two diabetes screenings every 12 months.	

Diabetic self-management training, services, and supplies

We pay for the following services for all people who have diabetes (whether they use insulin or not):

- Supplies to monitor your blood glucose, including the following:
  - a blood glucose monitor
  - blood glucose test strips
  - lancet devices and lancets
  - glucose-control solutions for checking the accuracy of test strips and monitors
- For people with diabetes who have severe diabetic foot disease, we pay for the following:
  - one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, **or**
  - one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)
- In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services.

This plan covers only OneTouch (made by LifeScan, Inc.) andACCU-CHECK (made by RocheDiagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a durable medical equipment (DME) provider these items will NOT be paid for. Lancets are limited to the following manufacturers: LifeScan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless,

This benefit is continued on the next page

Services that our plan pays for		
	Diabetic self-management training, services, and supplies (continued) 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. 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. This plan covers one blood glucose monitor every calendar year. Blood glucose test strips are covered for a maximum dose of 100 units every 30 days for patients who had a claim for insulin within the last 180 days. Blood glucose test strips are covered for a maximum dose of 50 units every 30 days for patients who have not had a claim for insulin within the last 180 days. Lancets are covered for 100 units every 30 days and up to 300 units for a 90 day supply.	
	Doula Services We pay for the services of a doula. A doula is a trained professional who provides continuous physical, emotional, and informational support to the birthing parent throughout the perinatal period. A doula can also provide informational support for community-based resources. A doula does not replace a licensed medical professional, and cannot perform clinical tasks.	

	Durable medical equipment (DME) and related supplies Refer to **Chapter 12** of your *Evidence of Coverage* for a definition of "Durable medical equipment (DME)." We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. With this *Evidence of Coverage,* we sent you our plan's list of DME. The list tells you the brands and makers of DME that we pay for. You may also find the most recent list of brands, makers, and suppliers on our website at https://shop.wellpoint.com/medicare. Generally, our plan covers any DME covered by Medicare and Medicaid from the brands and makers on this list. We do not cover other brands and makers unless your doctor or other provider tells us that you need the brand. However, if you are new to our plan and are using a brand of DME that is not on **This benefit is continued on the next page**	

	Durable medical equipment (DME) and related supplies (continued) our list, we will continue to pay for this brand for you for up to 90 days. During this time, talk with your doctor to decide what brand is medically right for you after the 90-day period. (If you disagree with your doctor, you can ask them to refer you for a second opinion.) If you (or your doctor) don't agree with our plan's coverage decision, you or your doctor may file an appeal. You can also file an appeal if you don't agree with your doctor's decision about what product or brand is right for your medical condition. For more information about appeals, refer to **Chapter 9** of your *Evidence of Coverage.* Therapeutic Continuous Glucose Monitors (CGMs) and related supplies are covered by Medicare when they meet Medicare National Coverage Determination (NCD) and Local Coverage Determinations (LCD) criteria. In addition, where there is not NCD/ LCD criteria, therapeutic CGM must meet any plan benefit limits, and the plan's evidence based clinical practice guidelines. Continuous Glucose Monitors are available as a covered benefit for people with diabetes who require the use of insulin and have difficulty controlling their blood sugar levels. This plan only covers FreeStyle Libre Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider these items will not be covered. Coverage limitations: • 2 Sensors per month • One receiver every 2 years Insulin pumps are different than a CGM and can be purchased through a DME provider. **This benefit is continued on the next page**	

Services that our plan pays for		
	Durable medical equipment (DME) and related supplies (continued) This plan covers only DUROLANE, EUFLEXXA, SUPARTZ, and Gel-SYN-3 Hyaluronic Acids. We will not cover other brands unless your provider tells us it is medically necessary. Talk to your provider to get prior authorization.	
	Early and Periodic Screening Diagnosis and Treatment (EPSDT) For members under 21 years of age, we pay for the following services: • well child care • preventive screenings • medical examinations • vision and hearing screenings and services • immunizations • lead screening • private duty nursing services We pay for private duty nursing for eligible EPSDT members under 21 years of age who live in the community and whose medical condition and treatment plan justify the need.	

	Emergency care
	
	Emergency care means services that are:
	• given by a provider trained to give emergency services, **and**
	• needed to treat a medical emergency.
	
	A medical emergency is a medical condition with severe pain or serious injury. The condition is so serious that, if it does not get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:
	• serious risk to your health or to that of your unborn child; **or**
	• serious harm to bodily functions; **or**
	• serious dysfunction of any bodily organ or part.
	• In the case of a pregnant woman in active labor, when:
	  ○ There is not enough time to safely transfer you to another hospital before delivery.
	  ○ A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.
	
	Emergency care coverage is worldwide.
	
	This benefit provides up to $100,000 per year in coverage for emergency/urgent services related to stabilizing your condition.
	
	Wellpoint covers services rendered beyond Medicare limits.
	
	This benefit is continued on the next page
		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 1-844-765-5160 (TTY 711).
		
		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

Services that our plan pays for		
	Emergency care (continued)	authorized by the plan. When you are outside the United States, this plan provides coverage for emergency/urgent services only. This is a supplemental benefit. This benefit applies if you are traveling outside the United States for less than six months.
	Everyday Options Allowance for Assistive Devices, Groceries[1], Over-the-Counter (OTC), and Utilities[1] **$269.00** monthly spending allowance The Everyday Options Allowance for Assistive Devices, Groceries, Over-the-Counter (OTC) products, and Utilities provides you with a combined monthly spending allowance on your Benefits Prepaid Card. This spending allowance can be used to pay for: • Assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more. • Food items like fresh meats, fruits, vegetables, pantry staples, and more. • OTC products like vitamins, first aid supplies, pain-relievers, and more. • Utilities including natural/propane gas, electric, water, cable, internet, or cell phone services. You may not use this card to purchase items such as tobacco or alcohol. The Benefits Prepaid Card is automatically loaded	

Services that our plan pays for		
	at the beginning of each month. Unused amounts do not roll over and must be used by the end of each month. You have a variety of convenient ways to use your benefit: 1) Shop in-store at participating retailers near you **This benefit is continued on the next page** **Everyday Options Allowance for Assistive Devices, Groceries[1], Over-the-Counter (OTC), and Utilities[1] (continued)** 2) Shop online on the approved vendor website 3) Shop on the approved vendor mobile app 4) Call to place an order 5) Order by mail (OTC and Assistive Devices only) 6) With your utility provider Note: • Orders for groceries and OTC products must be placed through the plan's approved vendor, or your purchase made at a participating retail store. Specific name brands may not be available, and quantities may be limited or restricted. Minimum order quantities and delivery fees may apply for online orders. See ordering site for details. • Assistive devices are limited to those offered by the approved vendor, and are subject to availability. Quantity limits may apply. Installation services are not included. Any repair or replacement is limited to the manufacturer's warranty. • Once you reach your monthly spending allowance, you are responsible for the remaining cost of your purchases. • You can only pay for your own items and cannot convert the card to cash. If your Benefits Prepaid Card is not accepted for payment or in the event of a card transaction failure, you may submit a claim form for reimbursement along with proof of payment. Contact	

Services that our plan pays for		
	information is listed on the back of your Benefits Prepaid Card. Claims must be submitted within 90 days of the date of payment on your receipt. [1]Value Based Insurance Design benefit	

Services that our plan pays for		
	Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing Services furnished by out-of-network providers are paid for directly by Medicaid.	

Services that our plan pays for		
	Federally qualified health centers (FQHC) Wellpoint covers outpatient and primary care services from community-based organizations.	
	Health and wellness education programs These programs are designed to enrich the health and lifestyles of members. • 24/7 NurseLine: As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. - see 24/7 NurseLine for more details • SilverSneakers® Fitness Program. See SilverSneakers® for more details.	
	Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. We pay for the following services: • routine hearing exams • diagnostic hearing exams and balance exams • otologic and hearing aid examinations prior to prescribing hearing aids • hearing aids, as well as associated accessories and supplies • exams for the purpose of fitting hearing aids • follow-up exams and adjustments • repairs after warranty expiration	You should get approval from your PCP before getting care from another provider. Seek care from your plan provider. If you have a medical need, your provider will start your treatment. He or she will arrange your care directly with the plan.

Services that our plan pays for		
	Help with certain chronic conditions **Healthy meals program** The following benefit is a Special Supplemental Benefits for the Chronically Ill and available to all members who meet the CMS guidelines criteria in Section C of this chapter. Depending on your specific conditions and healthcare needs, you may be eligible for a meal program to assist you in maintaining a healthy diet. This benefit provides up to 180 healthy, prepared meals delivered directly to your home each year. You can contact Member Services and a representative will arrange for you to be contacted to complete a nutritional assessment and schedule delivery of your meals. In order for us to provide your meals benefit, we, or a third party acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements. **Note:** we are unable to initiate your benefit without speaking to you. By requesting this benefit, you are expressly authorizing us to contact you by telephone.	
	HIV screening We pay for one HIV screening exam every 12 months for people who: • ask for an HIV screening test, **or** • are at increased risk for HIV infection. For women who are pregnant, we pay for up to three HIV screening tests during a pregnancy.	

Services that our plan pays for		
	Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services • physical therapy, occupational therapy, and speech therapy • medical and social services • medical equipment and supplies	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.

Services that our plan pays for		
	Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: • the drug or biological substance, such as an antiviral or immune globulin; • equipment, such as a pump; **and** • supplies, such as tubing or a catheter. Our plan covers home infusion services that include but are not limited to: • professional services, including nursing services, provided in accordance with your care plan; • member training and education not already included in the DME benefit; • remote monitoring; **and** • monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	

	Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • drugs to treat symptoms and pain • short-term respite care • home care The plan also covers certain durable medical equipment, as well as spiritual and grief counseling. For members under 21 years of age, both palliative and curative care are covered. **Hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare.** • Refer to **Section F** of this chapter for more information. **For services covered by our plan but not covered by Medicare Part A or Medicare Part B:** • Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. **For drugs that may be covered by our plan's Medicare Part D benefit:** • Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage*. **Note:** If you need non-hospice care, call your care manager and/or Member Services to arrange the services. Non-hospice care is care that is **not** related to your terminal prognosis. Our **This benefit is continued on the next page**	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. Room and board included only when servicers are delivered in institutional (non-residence) settings.

Services that our plan pays for		
	Hospice care (continued) plan covers all of your medical care not related to your terminal prognosis as it normally would. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
	Immunizations We pay for the following services: • pneumonia vaccine • flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • hepatitis B vaccine if you are at high or intermediate risk of getting hepatitis B • COVID-19 vaccines • other vaccines if you are at risk and they meet Medicare Part B coverage rules We pay for other vaccines that meet the Medicare Part D coverage rules. Refer to **Chapter 6** of your *Evidence of Coverage* to learn more.	You can get a flu or pneumonia shot without asking a doctor to refer you.

	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. We pay for the following services and other medically necessary services not listed here: • 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 • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse disorder treatment services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the **This benefit is continued on the next page**	Your provider must get an approval from the plan before you are admitted to a hospital for a procedure, rehabilitation or transplant that you and your doctor planned ahead. This is called getting prior authorization.

Services that our plan pays for		
	Inpatient hospital care (continued) pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) **$50** per day per covered person up to a maximum of **$100** per day per covered person consistent with IRS guidelines. • blood, including storage and administration • physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are you a Hosptial Inpatient or Outpatient? If You Have Medicare – Ask!". This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that our plan pays for		
	Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. We pay for acute inpatient hospitalization in a general hospital, regardless of the admitting diagnosis or treatment. The plan covers the following services: • inpatient services in a psychiatric hospital • services in a general hospital, psychiatric unit of an acute care hospital, Short Term Care Facility (STCF), or critical access hospital • Inpatient Medical Detox (Medically Managed Inpatient Withdrawal Management in a hospital setting)	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. For emergency care, call 911 or go to the nearest emergency facility. For non-emergency care, call your PCP or other plan provider. If you have a medical need, your provider will start your treatment. He or she will arrange your care directly with the plan.

Services that our plan pays for		
	Kidney disease services and supplies We pay for the following services: • Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. • Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in **Chapter 3** of your *Evidence of Coverage*, or when your provider for this service is temporarily unavailable or inaccessible. • Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care • Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Your Medicare Part B drug benefit pays for some drugs for dialysis. For information, refer to "Medicare Part B prescription drugs" in this chart.	

Services that our plan pays for		
🍎	**Lung cancer screening** Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, **and** • have a counseling and shared decision-making visit with your doctor or other qualified provider, **and** • have smoked at least 1 pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified provider.	
	Managed Long Term Services and Supports (MLTSS) The MLTSS program provides Home- and Community-Based services for members that require the level of care typically provided in a Nursing Facility, and allows them to receive necessary care in a residential or community setting. This MLTSS program is available to members who meet certain clinical and financial requirements. MLTSS services include (but are not limited to): • assisted living services • cognitive, speech, occupational, and physical therapy • chore services • home-delivered meals • residential modifications (such as the installation of ramps or grab bars) • vehicle modifications • social adult day care • non-medical transportation	

Services that our plan pays for		
	Medical Day Care This benefit is for people with physical and/or cognitive impairments. Our plan pays for preventive, diagnostic, therapeutic and rehabilitative services under medical and nursing supervision in an ambulatory care setting to meet the needs of individuals with physical and/or cognitive impairments in order to support their community living.	
🍎	**Medical nutrition therapy** This benefit is for people with diabetes or kidney disease without dialysis. It is also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during your first year that you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	
	Medical supplies Wellpoint covers services rendered beyond Medicare limits for approved procedures and services.	

Services that our plan pays for		
🍎	**Medicare Diabetes Prevention Program (MDPP)** Our plan pays for MDPP services. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, **and** • increased physical activity, **and** • ways to maintain weight loss and a healthy lifestyle.	
	Medicare community resource support As a member, your plan provides the support of a community resource outreach team to help bridge the gap between your medical benefits and the resources available to you in your community. Our team will assist you by providing information and education about community-based services and support programs in your area. If you have any questions about this benefit, call Member Services at 1-844-765-5160 (TTY 711).	

	Medicare Part B prescription drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • 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 • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • 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) • IV immune globulin for the home treatment of primary immune deficiency diseases We also cover some vaccines under our Medicare Part B and Medicare Part D prescription drug benefit. **Chapter 5** of your *Evidence of Coverage* explains our outpatient prescription drug benefit. It explains rules you must follow to have prescriptions covered. **Chapter 6** of your *Evidence of Coverage* gives more information about the *Explanation of Benefits (*EOB) and how it helps you track your drug coverage.	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.

Services that our plan pays for		
	Nonphysician services Wellpoint covers services rendered beyond Medicare limits (within the scope of practice and in accordance with state certification/licensure requirements, standards and practices) by certified nurse midwives, certified nurse practitioners, clinical nurse specialists, physician assistants, social workers, physical therapists and psychologists.	
	NurseLine As a member, you have access to a 24-hour nurse line, seven days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is available anytime, including weekends and holidays. Plus, your call is always confidential. Call the 24/7 NurseLine at 1-844-765-5160. TTY users should call 711.	
	Nursing facility care A nursing facility (NF) is a place that provides care for people who cannot get care at home but who do not need to be in a hospital. Services that we pay for include, but are not limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy **This benefit is continued on the next page**	

Services that our plan pays for		
	Nursing facility care (continued) • drugs given 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 • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	

Services that our plan pays for		
🍎	**Obesity screening and therapy to keep weight down** If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	
	Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD): • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing)	

Services that our plan pays for		
	Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. • other outpatient diagnostic tests	Your provider must get an approval from the plan before you get high-tech imaging or certain diagnostic and therapeutic radiology and lab services. This is called getting prior authorization. These include but are not limited to: Sleep studies and related equipment and supplies, radiation therapy, PET, CT, SPECT and MRI scans, heart tests called Echocardiograms, diagnostic lab tests and genetic testing.

Services that our plan pays for		
	Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf. or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, seven days a week.	

Services that our plan pays for		

	Outpatient hospital services
	
	We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as:
	• services in an emergency department or outpatient clinic, such as outpatient surgery or observation services
	  ○ Observation services help your doctor know if you need to be admitted to the hospital as "inpatient."
	  ○ Sometimes you can be in the hospital overnight and still be "outpatient."
	  ○ You can get more information about being inpatient or outpatient in this fact sheet: www.medicare.gov/sites/default/files/2021-10/11435-Inpatient-or-Outpatient.pdf.
	• labs 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 needed without it
	• X-rays and other radiology services billed by the hospital
	• medical supplies, such as splints and casts
	• preventive screenings and services listed throughout the Benefits Chart
	• some drugs that you can't give yourself
		Additional information about other outpatient services can be found 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 Prescription Drugs entry on page 93 for information on certain drugs and biologicals.

Services that our plan pays for		
	Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker • a clinical nurse specialist • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws • an Independent Practitioner Network or IPN (psychiatrist, psychologist, or Advanced Practice Nurse (APN)) Additionally, the plan covers the following services: • adult mental health rehabilitation (supervised group homes and apartments) • mental health outpatient (clinic/hospital services) • partial care and medication management	Your provider must get an approval from the plan before you get outpatient mental health services. This is called getting prior authorization.

Services that our plan pays for		
	Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. Wellpoint also covers cognitive rehabilitation therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.	You may need 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.

Services that our plan pays for		
	Outpatient substance use disorder treatment services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center • extended-release Naltrexone (vivitrol) treatment The plan covers substance use disorder screening, referrals, prescription drugs, and treatment of conditions. Covered services include, but are not limited to, the following: • non-medical detoxification/non-hospital based withdrawal management • substance use disorder short term residential • ambulatory withdrawal management with extended on-site monitoring/ambulatory detoxification • substance use disorder partial care • substance use disorder intensive outpatient • substance use disorder outpatient • opioid treatment services (methadone and non-methadone medication assisted treatment) ○ Refer to “Opioid treatment program (OTP) services” earlier in this chart for details. • Peer Recovery Support Services (PRSS)	Your provider must get an approval from the plan before you get outpatient substance use disorder treatment services. This is called getting prior authorization.

Services that our plan pays for		
	Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers.	Your provider must get an approval from the plan before you get some types of surgery as an outpatient. Some examples include UP3, bariatric and orthopedic surgery. This is called getting prior authorization. Call us to learn more.
	Partial hospitalization services Partial hospitalization is a structured program of active psychiatric treatment. It is offered as a hospital outpatient service or by a community mental health center. It is more intense than the care you get in your doctor's or therapist's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's or therapist's office but less intense than partial hospitalization. Wellpoint covers intensive and time-limited acute psychiatric service for beneficiaries of all ages. Coverage extends beyond Medicare Part B limits. Psychiatric acute partial hospital: Coverage is limited to six months per individual admission in this setting. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	Your provider must get an approval from the plan before each partial hospitalization for mental health or substance use disorder treatment. This is called getting prior authorization.

Services that our plan pays for		
	Personal Care Assistance (PCA) Covers health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a registered professional nurse, as certified by a physician in accordance with a beneficiary's written plan of care.	
	Personal Emergency Response System Coverage of one personal emergency response system and monthly monitoring in the member’s hom when arranged by the plan with a contracted vendor. The Personal Emergency Response System benefit provides an in-home device to notify the appropriate personnel of an emergency (e.g. a fall). Please call Member Services at the number at the bottom of this page for more information or to request the unit.	

Services that our plan pays for	
Physician/provider services, including doctor's office visits We pay for the following services: • medically necessary health care or surgery services given in places such as: • physician's office • certified ambulatory surgical center • hospital outpatient department • consultation, diagnosis, and treatment by a specialist • basic hearing and balance exams given by your primary care provider or specialist, if your doctor orders them to find out whether you need treatment • Certain telehealth services, including those for consultation, diagnosis, and treatment by a physician or practitioner. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. • telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home • telehealth services to diagnose, evaluate, or treat symptoms of a stroke • telehealth services for members with a substance use disorder or co-occurring mental health disorder • telehealth services for diagnosis, evaluation, and treatment of mental health disorders **This benefit is continued on the next page**	

Services that our plan pays for		

	Physician/provider services, including doctor's office visits (continued)
	• telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
	• virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes
	• evaluation of video and/or images you send to your doctor, interpretation, and follow-up by your doctor within 24 hours
	• consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient
	• second opinion before 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
	  ○ pulling teeth before radiation treatments of neoplastic cancer
	  ○ services that would be covered when provided by a physician
	• Wellpoint covers services rendered beyond Medicare limits.	

Services that our plan pays for		
	Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • routine exams • therapeutic shoes or inserts for those with severe diabetic foot disease, and exams to fit those shoes or inserts.	Excludes routine hygienic care of the feet, including the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, in the absence of a pathological condition.
	Private Duty Nursing (PDN) This benefit is for eligible beneficiaries under 21 years of age who live in the community and whose medical condition and treatment plan justify the need. It is covered for MLTSS members of any age.	
	Prostate cancer screening exams For men age 50 and over, (and for men 40 and older with a family history of prostate cancer or other risk factors), we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	Seek care from your plan provider. If you have a medical need, your provider will start your treatment. He or she will arrange your care directly with the plan.

Services that our plan pays for		
	Prosthetic devices and related supplies Prosthetic devices replace all or part of a body part or function. We pay for the following prosthetic devices, and maybe other devices not listed here: • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic devices. We also pay to repair or replace prosthetic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details.	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. 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.
	Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD.	

	Remote access technologies LiveHealth Online lets you see board-certified doctors and licensed therapists/psychologists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health insurance card ready – you'll need it to answer some questions. **Sign up for free:** • You must enter your health insurance information during enrollment, so have your member ID card ready when you sign up. Benefits of a video doctor visit: • The visit is just like seeing your regular doctor face to face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.[1] • If you're feeling stressed, worried or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and see a therapist or psychologist in four days or less.[2] Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is the trade name of Health Management Corporation, a separate company, providing telehealth services on behalf of this plan. [1]Prescription is prescribed based on physician recommendations and state regulations (rules). [2]Appointments are based on therapist/ psychologist availability. Video psychologists or therapists cannot prescribe medications.	

Services that our plan pays for	
Screening for lung cancer with low-dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible enrollees are:** people aged 50-77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years or who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified nonphysician 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.	

Services that our plan pays for	
Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	

	SilverSneakers SilverSneakers® by Trivity Health The SilverSneakers fitness program is your fitness benefit. It includes: • Access to 13,000+ fitness locations • Use of exercise equipment • Group exercise classes designed for all levels and abilities • A member website • Support all along the way SilverSneakers classes are offered in fitness locations' classrooms. More than 70 SilverSneakers Flex class options are offered in neighborhood locations. SilverSneakers FLEX® classes include Latin dance, tai chi, yoga and walking groups. Three SilverSneakers BOOM™ classes, MIND, MUSCLE and MOVE IT, offer more intense workouts inside the gym. All classes are led by certified instructors. To get started: Simply show your personal SilverSneakers ID number at the front desk of any SilverSneakers fitness location. Visit silversneakers.com to: • get your SilverSneakers ID number • find locations • see class descriptions If you have questions, please call 1-888-423-4632 (TTY: 711), Monday through Friday, 8 a.m. to 8 p.m. EST. At-home kits are offered for members who want to start working out at home or for those who can't get to a fitness location due to injury, illness or being homebound. SilverSneakers is not just a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. **This benefit is continued on the next page**	

Services that our plan pays for		
	SilverSneakers (continued) The SilverSneakers fitness program is provided by Tivity Health, an independent company. Tivity Health, SilverSneakers, SilverSneakers BOOM and SilverSneakers FLEX are registered trademarks or trademarks of Tivity Health, Inc. and/or its subsidiaries and/or affiliates in the USA and/or other countries. ®2017 Tivity Health, Inc. All rights reserved.	

Services that our plan pays for		
	Skilled nursing facility (SNF) care We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by nursing facilities • lab tests given by nursing facilities • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services • long term (custodial) care in a nursing facility You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital	Your provider must get approval from the plan before you get skilled nursing care. This is called getting prior authorization.

Services that our plan pays for		
	Smoking and tobacco use cessation If you use tobacco, do not have signs or symptoms of tobacco-related disease, and want or need to quit: • We pay for two quit attempts in a 12-month period as a preventive service. This service is free for you. Each quit attempt includes up to four face-to-face counseling 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 pay for two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. The plan also covers over-the-counter (OTC) smoking cessation products, including nicotine gums, nicotine lozenges and nicotine patches.	

Services that our plan pays for		
	Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist trained in both basic and advanced life support techniques	

Services that our plan pays for		
	Transportation Medicaid Fee-for-Service directly covers non-emergency transportation. Covered services include mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and livery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). All non-emergency transportation is arranged through the state's transportation vendor, Modivcare. To schedule transportation, call Modivcare at 1-866-527-9933. You can also ask your PCP or Care Manager to help you to arrange this service. Please call your care manager *and/or* Member Services at 1-844-765-5160 (TTY: 711). **Transportation: nonhealth related** This plan provides 24 one-way transportation trips to grocery stores, SilverSneakers classes, religious services, community centers, banks and Medicare or other government offices (including DMV). To schedule transportation please call 1-866-483-9523.	

Services that our plan pays for		
	Urgently needed care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, **or** • a sudden medical illness, **or** • an injury, **or** • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider beause given your circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). Wellpoint covers services rendered beyond Medicare limits. When you are outside the United States, this plan provides coverage for emergency/urgent services only. This is a supplemental benefit and not a benefit covered under the Federal Medicare program. This benefit applies if you are traveling outside the United States for less than six months. This benefit provides up to $25,000 per year in coverage for emergency/urgent services related to stabilizing your condition.	

	Vision care
	
	We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye, including a comprehensive eye exam once per year for all members. For example, this includes annual eye exams for diabetic retinopathy for people with diabetes and treatment for age-related macular degeneration.
	
	For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include:
	• people with a family history of glaucoma
	• people with diabetes
	• African-Americans who are age 50 and over
	• Hispanic Americans who are 65 or over
	
	For all other members age 35 or older, a glaucoma screening is covered every five years.
	
	We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.
	
	If you have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.
	
	The plan also covers the following:
	• optometrist services and optical appliances, including artificial eyes, low vision devices, vision training devices, and intraocular lenses
	• replacement lenses and frames (or contact lenses)
	  ○ once every 24 months for beneficiaries age 19 through 59, **or**
	  ○ once per year for beneficiaries 18 years of age or younger, **or**
	  ○ once per year for beneficiaries 60 years of age or older	

Services that our plan pays for		
🍎	**"Welcome to Medicare" preventive visit** We cover the one-time "Welcome to Medicare" preventive visit. The visit includes: • a review of your health, • education and counseling about the preventive services you need (including screenings and shots), **and** • referrals for other care if you need it **Note:** We cover the "Welcome to Medicare" preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor's office you want to schedule your "Welcome to Medicare" preventive visit.	

E. Benefits covered outside of our plan

We don't cover the following services, but they are available through Medicare or NJ FamilyCare.

- Non-emergency transportation, including mobile assistance vehicles (MAVs); non-emergency basic life support (BLS) ambulance (stretcher); and delivery transportation services (such as bus and train fare or passes, or car service and reimbursement for mileage). These services are paid for directly by Medicaid (also known as Medicaid Fee-for-Service).

E1. Hospice care

You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. The plan must help you find Medicare-certified hospice programs. Your hospice doctor can be a network provider or an out-of-network provider.

Refer to the Benefits Chart in **Section D** for more information about what we pay for while you are getting hospice care services.

For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis

- The hospice provider bills Medicare for your services. Medicare pays for hospice services related to your terminal prognosis. You pay nothing for these services.

For services covered by Medicare Part A or Medicare Part B that are not related to your terminal prognosis

- The provider will bill Medicare for your services. Medicare will pay for the services covered by Medicare Part A or Medicare Part B. You pay nothing for these services.

For drugs that may be covered by our plan's Medicare Part D benefit

- Drugs are never covered by both hospice and our plan at the same time. For more information, refer to **Chapter 5** of your *Evidence of Coverage*.

Note: If you need non-hospice care, call your care manager to arrange the services. Non-hospice care is care not related to your terminal prognosis.

F. Benefits not covered by our plan, Medicare, or NJ FamilyCare

This section tells you about benefits excluded by our plan. "Excluded" means that we do not pay for these benefits. Medicare and Medicaid do not pay for them either.

The list below describes some services and items not covered by us under any conditions and some excluded by us only in some cases.

We do not pay for excluded medical benefits listed in this section (or anywhere else in this *Evidence of Coverage*) except under specific conditions listed. Even if you receive the services at an emergency facility, the plan will not pay for the services. If you think that our plan should pay for a service that is not covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of your *Evidence of Coverage*.

In addition to any exclusions or limitations described in the Benefits Chart, our plan does not cover the following items and services:

- services considered not "reasonable and medically necessary", according Medicare and NJ FamilyCare standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them.

Refer to **Chapter 3** of your *Evidence of Coverage* for more information on clinical research studies. Experimental treatment and items are those that are not generally accepted by the medical community.

- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it is needed because of an accidental injury or to improve a part of the body that is not shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines, and as described in Chiropractic Services in the Benefits Chart in **Section D**
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the 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
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomyand LASIK surgery
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities

Chapter 5: Getting your outpatient prescription drugs

Introduction

This chapter explains rules for getting your outpatient prescription drugs. These are drugs that your provider orders for you that you get from a pharmacy or by mail-order. They include drugs covered under Medicare Part D and NJ FamilyCare. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

We also cover the following drugs, although they are not discussed in this chapter:

- **Drugs covered by Medicare Part A.** These generally include drugs given to you while you are in a hospital or nursing facility.
- **Drugs covered by Medicare Part B.** These include some chemotherapy drugs, some drug injections given to you during an office visit with a doctor or other provider, and drugs you are given at a dialysis clinic. To learn more about what Medicare Part B drugs are covered, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- In addition to the plan's Medicare Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please refer to **Chapter 5**, **Section F** "If you are in a Medicare-certified hospice program."

Rules for our plan's outpatient drug coverage

We usually cover your drugs as long as you follow the rules in this section.

You must have a doctor or other provider write your prescription, which must be valid under applicable state law. This person often is your primary care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists.

You generally must use a network pharmacy to fill your prescription.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the "Drug List" for short.

- If it is not on the Drug List, we may be able to cover it by giving you an exception.

- Refer to **Chapter 9** to learn about asking for an exception.

Your drug must be used for a medically accepted indication. This means that use of the drug is either approved by the Food and Drug Administration (FDA) or supported by certain medical references. Your doctor may be able to help identify medical references to support the requested use of the prescribed drug. “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.

Table of Contents

A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies.

To find a network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website or contact Member Services or your care manager.

A2. Using your Member ID Card when you fill a prescription

To fill your prescription, **show your Member ID Card** at your network pharmacy. The network pharmacy bills us for your covered prescription drug.

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information.

If the pharmacy can't get the necessary information, you may have to pay the full cost of the prescription when you pick it up. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We will do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of your *Evidence of Coverage*.
- If you need help getting a prescription filled, contact Member Services or your care manager.

A3. What to do if you change your network pharmacy

If you change pharmacies and need a prescription refill, you can either ask to have a new prescription written by a provider or ask your pharmacy to transfer the prescription to the new pharmacy if there are any refills left.

If you need help changing your network pharmacy, contact Member Services or your care manager.

A4. What to do if your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you need to find a new network pharmacy.

To find a new network pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

A5. Using 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.

Please refer to your Provider and Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, call Member Services.

- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
    - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
    - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- 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 find a specialized pharmacy, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services or your care manager.

A6. Using mail-order services to get your drugs

Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 100-day supply.

Filling prescriptions by mail

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

Usually, a mail-order prescription arrives within 14 days. 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.

Mail-order processes

Mail-order service has different procedures for new prescriptions it gets from you, new prescriptions it gets directly from your provider's office, and refills on your mail-order prescriptions.

1. **New prescriptions the pharmacy gets from you**

   The pharmacy automatically fills and delivers new prescriptions it gets from you.

2. **New prescriptions the pharmacy gets from your provider's office**

   The pharmacy automatically fills and delivers new prescriptions it gets from health care providers, without checking with you first, if:

   - You used mail-order services with our plan in the past, **or**
   - You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for 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 used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, contact us by calling the Member Services phone number on your membership card.

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy contacts you each time it gets a new prescription from a health care provider to find out if you want the medication filled and shipped immediately.

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it is shipped.
- Respond each time the pharmacy contacts you, 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 you get directly from your health care provider's office, contact us by calling the Member Services phone number on your membership card.

3. Refills on mail-order prescriptions

For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug.

- The pharmacy contacts you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough of your medication or if your medication has changed.
- If you choose not to use our auto refill program, contact your pharmacy 30 days before your current prescription will run out to make sure your next order is shipped to you in time.

To opt out of our program that automatically prepares mail-order refills, contact us by calling the Member Services phone number on your membership card.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping.

A7. Getting a long-term supply of drugs

You can get a long-term 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.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. The *Provider and Pharmacy Directory* tells you which pharmacies can give you a long-term supply of maintenance drugs. You can also call your care manager or Member Services for more information.

For certain kinds of drugs, you can use our plan's network mail-order services to get a long-term supply of maintenance drugs. Refer to **Section A6** to learn about mail-order services.

A8. Using a pharmacy not in our plan's network

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan.

We pay for prescriptions filled at an out-of-network pharmacy in the following cases:

- You are traveling within the United States and its territories and become ill or lose or run out of your prescription drugs.
- You are traveling within the United States and its territories, and 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 cases, check with your care manager or Member Services first to find out if there's a network pharmacy nearby.

A9. Paying you back for a prescription

If you must use an out-of-network pharmacy, you must generally pay the full cost when you get your prescription. You can ask us to pay you back.

To learn more about this, refer to **Chapter 7** of your *Evidence of Coverage*.

B. Our plan's Drug List

We have a *List of Covered Drugs.* We call it the "Drug List" for short.

We select the drugs on the Drug List with the help of a team of doctors and pharmacists. The Drug List also tells you the rules you need to follow to get your drugs.

We generally cover a drug on our plan's Drug List when you follow the rules we explain in this chapter.

If we cover a drug only for some medical conditions, we clearly identify it on our Drug List and in Medicare Plan Finder along with the specific medical conditions covered.

B1. Drugs on our Drug List

Our Drug List includes drugs covered under Medicare Part D and some prescription and over-the-counter (OTC) drugs and products covered under NJ FamilyCare.

Our Drug List includes brand name drugs and generic drugs.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example drugs that are based on a protein) are called biological products. On our Drug List, when we refer to "drugs" this could mean a drug or a biological product.

Generic drugs have the same active ingredients as brand name drugs. Generally, generic drugs work just as well as brand name drugs and usually cost less. There are generic drug substitutes available for many brand name drugs. Talk to your provider if you have questions about whether a generic or a brand name drug will meet your needs.

Our plan also covers certain OTC drugs and products. Some OTC drugs cost less than prescription drugs and work just as well. For more information, call Member Services.

B2. How to find a drug on our Drug List

To find out if a drug you take is on our Drug List, you can:

- Visit our plan's website at https://shop.wellpoint.com/medicare. The Drug List on our website is always the most current one.
- Call your care manager or Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.

- Use our “Real Time Benefit Tool” at https://shop.wellpoint.com/medicare or call your care manager or Member Services. With this tool you can search for drugs on the Drug List to get an estimate of what you will pay and if there are alternative drugs on the Drug List that could treat the same condition.

B3. Drugs not on our Drug List

We don’t cover all prescription drugs. Some drugs are not on our Drug List because the law doesn’t allow us to cover those drugs. In other cases, we decided not to include a drug on our Drug List.

Our plan does not pay for the kinds of drugs described in this section. These are called **excluded drugs**. If you get a prescription for an excluded drug, you may need to pay for it yourself. If you think we should pay for an excluded drug because of your case, you can make an appeal. Refer to **Chapter 9** of your *Evidence of Coverage* for more information about appeals.

Here are three general rules for excluded drugs:

1. Our plan’s outpatient drug coverage (which includes Medicare Part D and NJ FamilyCare drugs) cannot pay for a drug that Medicare Part A or Medicare Part B already covers. Our plan covers drugs covered under Medicare Part A or Medicare Part B for free, but these drugs aren’t considered part of your outpatient prescription drug benefits.
2. Our plan cannot cover a drug purchased outside the United States and its territories.
3. Use of the drug must be approved by the FDA or supported by certain medical references as a treatment for your condition. Your doctor may prescribe a certain drug to treat your condition, even though it wasn’t approved to treat the condition. This is called “off-label use.” Our plan usually doesn’t cover drugs prescribed for off-label use.

Also, by law, Medicare or NJ FamilyCare cannot cover the types of drugs listed below.

- drugs used to promote fertility
- drugs used for the relief of cough or cold symptoms
- drugs used for cosmetic purposes or to promote hair growth
- prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations

- drugs used for the treatment of sexual or erectile dysfunction
- drugs used for the treatment of anorexia, weight loss or weight gain
- outpatient drugs made by a company that says you must have tests or services done only by them

C. Limits on some drugs

For certain prescription drugs, special rules limit how and when our plan covers them. Generally, our rules encourage you to get a drug that works for your medical condition and is safe and effective. When a safe, lower-cost drug works just as well as a higher-cost drug, we expect your provider to prescribe the lower-cost drug.

If there is a special rule for your drug, it usually means that you or your provider must take extra steps for us to cover the drug. For example, your provider may have to tell us your diagnosis or provide results of blood tests first. If you or your provider thinks our rule should not apply to your situation, ask us to make an exception. We may or may not agree to let you use the drug without taking extra steps.

To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage*.

1. Limiting use of a brand name drug when a generic version is available

Generally, a generic drug works the same as a brand name drug and usually costs less. If there is a generic version of a brand name drug available, our network pharmacies give you the generic version.

- We usually do not pay for the brand name drug when there is an available generic version.
- However, if your provider told us the medical reason that the generic drug won't work for you ***or*** wrote "No substitutions" on your prescription for a brand name drug, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your doctor must get approval from our plan before you fill your prescription. If you don't get approval, we may not cover the drug.

3. Trying a different drug first

In general, we want you to try lower-cost drugs that are as effective before we cover drugs that cost more. For example, if Drug A and Drug B treat the same medical condition, and Drug A costs less than Drug B, we may require you to try Drug A first.

If Drug A does **not** work for you, then we cover Drug B. This is called step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, we might limit how much of a drug you can get each time you fill your prescription.

To find out if any of the rules above apply to a drug you take or want to take, check our Drug List. For the most up-to-date information, call Member Services or check our website at https://shop.wellpoint.com/medicare. If you disagree with our coverage decision based on any of the above reasons you may request an appeal. Please refer to **Chapter 9** of the *Evidence of Coverage.*

D. Reasons your drug might not be covered

We try to make your drug coverage work well for you, but sometimes a drug may not be covered in the way that you like. For example:

- Our plan doesn't cover the drug you want to take. The drug may not be on our Drug List. We may cover a generic version of the drug but not the brand name version you want to take. A drug may be new, and we haven't reviewed it for safety and effectiveness yet.
- Our plan covers the drug, but there are special rules or limits on coverage. As explained in the section above, some drugs our plan covers have rules that limit their use. In some cases, you or your prescriber may want to ask us for an exception.

There are things you can do if we don't cover a drug the way you want us to cover it.

D1. Getting a temporary supply

In some cases, we can give you a temporary supply of a drug when the drug is not on our Drug List or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

To get a temporary supply of a drug, you must meet the two rules below:

1. The drug you've been taking:
    - is no longer on our Drug List **or**
    - was never on our Drug List **or**
    - is now limited in some way.
2. You must be in one of these situations:
    - You were in our plan last year.
        - We cover a temporary supply of your drug **during the first 90 days of the calendar year**.
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
    - You are new to our plan.
        - We cover a temporary supply of your drug **during the first 90 days of your membership in our plan.**
        - This temporary supply is for up to 30 days.
        - If your prescription is written for fewer days, we allow multiple refills to provide up to a maximum of 30 days of medication. You must fill the prescription at a network pharmacy.
        - Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.

- You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
    - We cover one 34-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

D2. Asking for a temporary supply

To ask for a temporary supply of a drug, call Member Services.

When you get a temporary supply of a drug, talk with your provider as soon as possible to decide what to do when your supply runs out. Here are your choices:

- Change to another drug.

  Our plan may cover a different drug that works for you. Call Member Services to ask for a list of drugs we cover that treat the same medical condition. The list can help your provider find a covered drug that may work for you.

  OR

- Ask for an exception.

  You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that is not on our Drug List or ask us to cover the drug without limits. If your provider says you have a good medical reason for an exception, they can help you ask for one.

D3. Asking for an exception

If a drug you take will be taken off our Drug List or limited in some way next year, we allow you to ask for an exception before next year.

- We tell you about any change in the coverage for your drug for next year. Ask us to make an exception and cover the drug for next year the way you would like.
- We answer your request for an exception within 72 hours after we get your request (or your prescriber's supporting statement).

To learn more about asking for an exception, refer to **Chapter 9** of your *Evidence of Coverage*.

If you need help asking for an exception, contact Member Services or your care manager.

E. Coverage changes for your drugs

Most changes in drug coverage happen on January 1, but we may add or remove drugs on our Drug List during the year. We may also change our rules about drugs. For example, we may:

- Decide to require or not require prior approval (PA) for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).

For more information on these drug rules, refer to **Section C**.

If you take a drug that we covered at the **beginning** of the year, we generally will not remove or change coverage of that drug **during the rest of the year** unless:

- a new, cheaper drug comes on the market that works as well as a drug on our Drug List now, **or**
- we learn that a drug is not safe, **or**
- a drug is removed from the market.

To get more information on what happens when our Drug List changes, you can always:

- Check our current Drug List online at https://shop.wellpoint.com/medicare **or**
- Call Member Services at the number at the bottom of the page to check our current Drug List.

Some changes to our Drug List happen **immediately**. For example:

- **A new generic drug becomes available.** Sometimes, a new generic drug comes on the market that works as well as a brand name drug on our Drug List now. When that happens, we may remove the brand name drug and add the new generic drug.

  When we add the new generic drug, we may also decide to keep the brand name drug on the list but change its coverage rules or limits.

  - We may not tell you before we make this change, but we send you information about the specific change we made once it happens.

- You or your provider can ask for an "exception" from these changes. We send you a notice with the steps you can take to ask for an exception. Refer to **Chapter 9** of your *Evidence of Coverage f*or more information on exceptions.

- **A drug is taken off the market.** If the FDA says a drug you are taking is not safe or the drug's manufacturer takes a drug off the market, we take it off our Drug List. If you are taking the drug, we tell you. Your prescriber will also know about this change and can work with you to find another drug for your condition.

We may make other changes that affect the drugs you take. We tell you in advance about these other changes to our Drug List. These changes might happen if:

- The FDA provides new guidance or there are new clinical guidelines about a drug.
- We add a generic drug that is not new to the market **and**
  - Replace a brand name drug currently on our Drug List **or**
  - Change the coverage rules or limits for the brand name drug.
- We add a generic drug **and**
  - Replace a brand name drug currently on the Drug List **or**
  - Change the coverage rules or limits for the brand name drug.

When these changes happen, we:

- Tell you at least 30 days before we make the change to our Drug List **or**
- Let you know and give you a 30-day supply of the drug after you ask for a refill.

This gives you time to talk to your doctor or other prescriber. They can help you decide:

- If there is a similar drug on our Drug List you can take instead **or**
- If you should ask for an exception from these changes. To learn more about asking for exceptions, refer to **Chapter 9** of your *Evidence of Coverage*.

We may make changes to drugs you take that do not affect you now. For such changes, if you are taking a drug we covered at the **beginning** of the year, we generally do not remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you are taking or limit its use, then the change does not affect your use of the drug for the rest of the year.

F. Drug coverage in special cases

F1. In a hospital or a skilled nursing facility for a stay that our plan covers

If you are admitted to a hospital or skilled nursing facility for a stay our plan covers, we generally cover the cost of your prescription drugs during your stay. You will not pay a copay. Once you leave the hospital or skilled nursing facility, we cover your drugs as long as the drugs meet all of our coverage rules.

F2. In a long-term care facility

Usually, a long-term care facility, such as a nursing facility, has its own pharmacy or a pharmacy that supplies drugs for all of their residents. If you live in a long-term care facility, you may get your prescription drugs through the facility's pharmacy if it is part of our network.

Check your *Provider and Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it is not or if you need more information, contact Member Services.

F3. In a Medicare-certified hospice program

Drugs are never covered by both hospice and our plan at the same time.

- You may be enrolled in a Medicare hospice and require a pain, anti-nausea, laxative, or anti-anxiety drug that your hospice does not cover because it is not related to your terminal prognosis and conditions. In that case, our plan must get notification from the prescriber or your hospice provider that the drug is unrelated before we can cover the drug.
- To prevent delays in getting any unrelated drugs that our plan should cover, 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.

If you leave hospice, our plan covers all of your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, take documentation to the pharmacy to verify that you left hospice.

Refer to earlier parts of this chapter that tell about drugs our plan covers. Refer to **Chapter 4** of your *Evidence of Coverage* for more information about the hospice benefit.

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

Each time you fill a prescription, we look for possible problems, such as drug errors or drugs that:

- may not be needed because you take another drug that does the same thing
- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- have unsafe amounts of opioid pain medications

If we find a possible problem in your use of prescription drugs, we work with your provider to correct the problem.

G2. Programs to help you manage your drugs

Our plan has a program to help members with complex health needs. In such cases, you may be eligible to get services, at no cost to you, through a medication therapy management (MTM) program. This program is voluntary and free. This program helps you and your provider make sure that your medications are working to improve your health. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all of your medications and talk with you about:

- how to get the most benefit from the drugs you take
- any concerns you have, like medication costs and drug reactions
- how best to take your medications
- any questions or problems you have about your prescription and over-the-counter medication

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you

take, and when and why you take them.

- Information about safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your action plan and medication list.

- Take your action plan and medication list to your visit or anytime you talk with your doctors, pharmacists, and other health care providers.
- Take your medication list with you if you go to the hospital or emergency room.

MTM programs are voluntary and free to members who qualify. If we have a program that fits your needs, we enroll you in the program and send you information. If you do not want to be in the program, let us know, and we will take you out of it.

If you have questions about these programs, contact Member Services or your care manager.

G3. Drug management program for safe use of opioid medications

Our plan has a program that can help members safely use their prescription opioid medications and other medications that are frequently misused. This program is called a Drug Management Program (DMP).

If you use opioid medications that you get from several doctors or pharmacies or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, if we decide your use of prescription opioid or benzodiazepine medications is not safe, we may limit how you can get those medications. Limitations may include:

- Requiring you to get all prescriptions for those medications from a certain pharmacy and/or from a certain doctor
- Limiting the amount of those medications we cover for you

If we think that one or more limitations should apply to you, we send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You will have a chance to tell us which doctors or pharmacies you prefer to use and any information you think is important for us to know. If we decide to limit your coverage for these medications after you have a chance to respond, we send you another letter that confirms the limitations.

If you think we made a mistake, you disagree that you are at risk for prescription drug misuse, or you disagree with the limitation, you and your prescriber can make an appeal. If you make an appeal, we will review your case and give you our decision. If we continue to deny any part of your appeal related to limitations to your access to these medications, we automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of your *Evidence of Coverage*.)

The DMP may not apply to you if you:

- have certain medical conditions, such as cancer or sickle cell disease,
- are getting hospice, palliative, or end-of-life care, **or**
- live in a long-term care facility.

Chapter 6: What you pay for your Medicare and NJ FamilyCare Medicaid prescription drugs

Introduction

This chapter tells what you pay for your outpatient prescription drugs. By “drugs,” we mean:

- Medicare Part D prescription drugs, **and**
- Drugs and items covered under Medicaid**.**

Because you are eligible for NJ FamilyCare, you get “Extra Help” from Medicare to help pay for your Medicare Part D prescription drugs.

> **Extra Help** is a Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy,” or “LIS.”

Other key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

To learn more about prescription drugs, you can look in these places:

- Our *List of Covered Drugs*.
  - We call this the “Drug List.” It tells you:
    - Which drugs we pay for
    - If there are any limits on the drugs
  - If you need a copy of our Drug List, call Member Services. You can also find the most current copy of our Drug List on our website at https://shop.wellpoint.com/medicare.
- **Chapter 5** of your *Evidence of Coverage*.
  - It tells how to get your outpatient prescription drugs through our plan.

- It includes rules you need to follow. It also tells which types of prescription drugs our plan does not cover.
- When you use the plan's "Real Time Benefit Tool" to look up drug coverage (refer to Chapter 5, Section B2), the cost shown is provided in "real time" meaning the cost displayed in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can call your care manager or Member Services for more information.

- Our *Provider and Pharmacy Directory*.
  - In most cases, you must use a network pharmacy to get your covered drugs. Network pharmacies are pharmacies that agree to work with us.
  - The *Provider and Pharmacy Directory* lists our network pharmacies. Refer to **Chapter 5** of your *Evidence of Coverage* more information about network pharmacies.

Table of Contents

A. The *Explanation of Benefits* (EOB)

Our plan keeps track of your prescription drugs. We keep track of two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions.
- Your **total drug costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions, plus the amount we pay.

When you get prescription drugs through our plan, we send you a summary called the *Explanation of Benefits*. We call it the EOB for short. The EOB is not a bill. The EOB has more information about the drugs you. The EOB includes:

- **Information for the month**. The summary tells what prescription drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paying for you paid.
- **Year-to-date information.** This is your total drug costs and total payments made since January 1.
- **Drug price information**. This is the total price of the drug and any percentage change in the drug price since the first fill.
- **Lower cost alternatives**. When available, they appear in the summary below your current drugs. You can talk to your prescriber to find out more.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs do not count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our Drug List. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under NJ FamilyCare. These drugs are included in the Drug List.

B. How to keep track of your drug costs

To keep track of your drug costs and the payments you make, we use records we get from you and from your pharmacy. Here is how you can help us:

1. Use your Member ID Card.

Show your Member ID Card every time you get a prescription filled. This helps us know what prescriptions you fill and what you pay.

2. Make sure we have the information we need.

Give us copies of receipts for covered drugs that you paid for. You can ask us to pay you back for the drug.

Here are some times when you should give us copies of your receipts:

- When you buy 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 pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of your *Evidence of Coverage*.

3. Send us information about payments others have made for you.

Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the EOBs we send you.

When you get an EOB in the mail, make sure it is complete and correct.

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?

- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

For more information, you can call Wellpoint Full Dual Advantage (HMO D-SNP) Member Services or read the Wellpoint Full Dual Advantage (HMO D-SNP) *Evidence of Coverage* on our website at https://shop.wellpoint.com/medicare.

What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Wellpoint Full Dual Advantage (HMO D-SNP) Member Services. *You can also find answers to many questions on our website:* https://shop.wellpoint.com/medicare.

What about possible fraud?

If this summary shows drugs you're not taking or anything else that seems suspicious to you, please contact us.

- Call us at Wellpoint Full Dual Advantage (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

If you think something is wrong or missing, or if you have any questions, call Member Services. Keep these EOBs. They are an important record of your drug expenses.

C. You pay nothing for a one-month or long-term supply of drugs

With our plan, you pay nothing for covered drugs as long as you follow our rules. Refer to **Chapter 9** of the *Evidence of Coverage* to learn about how to file an appeal if you are told a drug will not be covered. To learn more about these pharmacy choices, refer to **Chapter 5** of your *Evidence of Coverage* and our *Provider and Pharmacy Directory*.

C1. Getting a long-term 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 100-day supply. There is no cost to you for a long-term supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *Evidence of Coverage* or our *Provider and Pharmacy Directory*.

D. Vaccinations

Important Message About What You Pay for Vaccines: Some vaccines are considered medical benefits. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).* Our plan covers adult Medicare Part D vaccines at no cost to you.

D1. What you need to know before you get a vaccination

We recommend that you call Member Services if you plan to get a vaccination.

- We can tell you about how our plan covers your vaccination.

D2. What you pay for a vaccination covered by Medicare Part D

What you pay for a vaccination depends on the type of vaccine (what you are being vaccinated for).

- Some vaccines are considered health benefits rather than drugs. These vaccines are covered at no cost to you. To learn about coverage of these vaccines, refer to the Benefits Chart in **Chapter 4** of your *Evidence of Coverage*.
- Other vaccines are considered Medicare Part D drugs. You can find these vaccines on our plan's Drug List. If the vaccine is recommended for adults by an organization called the **Advisory Committee or Immunization Practices (ACIP)** then the vaccine will cost you nothing.

Here are three common ways you might get a Medicare Part D vaccination.

1. You get the Medicare Part D vaccine and your shot at a network pharmacy.
   - For most adult Part D vaccines, you will pay nothing.
   - For other Part D vaccines, you pay nothing for the vaccine.
2. You get the Medicare Part D vaccine at your doctor's office, and your doctor gives you the shot.
   - You pay nothing to the doctor for the vaccine.
   - Our plan pays for the cost of giving you the shot.
   - The doctor's office should call our plan in this situation so we can make sure they know you only have to pay nothing for the vaccine.

3. You get the Medicare Part D vaccine medication at a pharmacy, and you take it to your doctor's office to get the shot.
    - For most adult Part D vaccines, you will pay nothing for the vaccine itself.
    - For other Part D vaccines, you pay nothing for the vaccine.
    - Our plan pays for the cost of giving you the shot.

Chapter 7: Asking us to pay a bill you got for covered services or drugs

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you do not agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Asking us to pay for your services or drugs

You should not get a bill for in-network services or drugs. Our network providers must bill the plan for your covered services and drugs after you get them. A network provider is a provider who works with the health plan.

We do not allow Wellpoint Full Dual Advantage (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, do not pay the bill and send the bill to us. To send us a bill, refer to Section B.

- If we cover the services or drugs, we will pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it is your right to be paid back.
    - If you paid for services covered by Medicare, we will pay you back.
- If we do not cover the services or drugs, we will tell you.

Contact Member Services or your Care Manager if you have any questions. If you get a bill and you don’t know what to do about it, we can help. You can also call if you want to tell us information about a request for payment you already sent to us.

Here are examples of times when you may need to ask us to pay you back or to pay a bill you got:

1. **When you get emergency or urgently needed health care from an out-of-network provider**

   Ask the provider to bill us.

   - If you pay the full amount when you get the care, ask us to pay you back. Send us the bill and proof of any payment you made.
   - You may get a bill from the provider asking for payment that you think you don’t owe. Send us the bill and proof of any payment you made.
       - If the provider should be paid, we will pay the provider directly.
       - If you already paid for the Medicare service, we will pay you back.

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes, and ask you to pay for your services. **Call Member Services** or your Care Manager at the number at the bottom of this page **if you get any bills.**

- Because we pay the entire cost for your services, you are not responsible for paying any costs. Providers should not bill you anything for these services.
- Whenever you get a bill from a network provider, send us the bill. We will contact the provider directly and take care of the problem.
- If you already paid a bill from a network provider for Medicare-covered services, send us the bill and proof of any payment you made. We will pay you back for your covered services.

3. If you are retroactively enrolled in our plan

Sometimes your enrollment in the plan can be retroactive. (This means that the first day of your enrollment has passed. It may have even been last year.)

- If you were enrolled retroactively and you paid a bill after the enrollment date, you can ask us to pay you back.
- Send us the bill and proof of any payment you made.

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

If you use an out-of-network pharmacy, you pay the full cost of your prescription.

- In only a few cases, we will cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of your *Evidence of Coverage* to learn more about out-of-network pharmacies.

5. When you pay the prescription cost because you don't have your Member ID Card with you

If you don't have your Member ID Card with you, you can ask the pharmacy to call us or look up your plan enrollment information.

- If the pharmacy can't get the information right away, you may have to pay the full

prescription cost yourself or return to the pharmacy with your Member ID Card.

- Send us a copy of your receipt when you ask us to pay you back.

6. When you pay the full prescription cost for a drug that's not covered

You may pay the full prescription cost because the drug isn't covered.

- The drug may not be on our *List of Covered Drugs* (Drug List) on our website, or it may have a requirement or restriction that you don't know about or don't think applies to you. If you decide to get the drug, you may need to pay the full cost.
    - If you don't pay for the drug but think we should cover it, you can ask for a coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
    - If you and your doctor or other prescriber think you need the drug right away, (within 24 hours), you can ask for a fast coverage decision (refer to **Chapter 9** of your *Evidence of Coverage*).
- Send us a copy of your receipt when you ask us to pay you back. In some cases, we may need to get more information from your doctor or other prescriber to pay you back for the drug.

When you send us a request for payment, we review it and decide whether the service or drug should be covered. This is called making a "coverage decision." If we decide the service or drug should be covered, we pay for it.

If we deny your request for payment, you can appeal our decision. To learn how to make an appeal, refer to **Chapter 9** of your *Evidence of Coverage*.

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your Care Manager for help.

To make sure you give us all the information we need to decide, you can fill out our claim form to ask for payment.

- You aren't required to use the form, but it helps us process the information faster.

- You can get the form on our website (https://shop.wellpoint.com/medicare), or you can call Member Services and ask for the form.

Mail your request for payment for **medical services** together with any bills or receipts to this address:

Wellpoint
P.O. Box 61010
Virginia Beach, VA 23466-1010

Mail your request for payment for **Part D prescription drugs** together with any bills or receipts to this address:

CarelonRx
Claims Department – Part D Services
P.O. Box 52077
Phoenix, AZ 85072-2077

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you haven't paid, we will pay the provider directly.

Chapter 3 of your *Evidence of Coverage* explains the rules for getting your services covered. **Chapter 5** of your *Evidence of Coverage* explains the rules for getting your Medicare Part D prescription drugs covered.

- If we decide not to pay for the service or drug, we will send you a letter with the reasons. The letter also explains your rights to make an appeal.
- To learn more about coverage decisions, refer to Chapter 9 Section E.

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.”

The formal appeals process has detailed procedures and deadlines. To learn more about appeals, refer to **Chapter 9** of your *Evidence of Coverage*:

- To make an appeal about getting paid back for a health care service, refer to **Section F**.
- To make an appeal about getting paid back for a drug, refer to **Section G**.

Chapter 8: Your rights and responsibilities

Introduction

This chapter includes your rights and responsibilities as a member of our plan. We must honor your rights. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. Your right to get services and information in a way that meets your needs

We must ensure **all** services are provided to you in a culturally competent and accessible manner. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you are in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. To obtain materials in one of these alternative formats, please call Member Services or write to Wellpoint Full Dual Advantage (HMO D-SNP) P.O. Box 61010 Virginia Beach, VA 23466-1010, 1-844-765-5160.
    - To get information in a way that you can understand, call Member Services. Our plan has people who can answer questions in different languages. Our plan can also give you materials in languages other than English and in formats such as large print, braille, or audio. You can call Member Services and ask to have materials sent to you in Spanish.
    - You can get this document for free in other languages and formats, such as large print, braille or audio. Call Member Services at the number listed on the bottom of this page. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at https://shop.wellpoint.com/medicare.

If you have trouble getting information from our plan because of language problems or a disability and you want to file a complaint, call:

- Medicare at 1-800-MEDICARE (1-800-633-4227). You can call 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- NJ Medicaid at 1-800-701-0710. TTY users should call 711.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

A. Su derecho a recibir servicios e información de una manera que satisfaga sus necesidades

Debemos asegurarnos de que se le proporcionen todos los servicios de una forma culturalmente adecuada y accesible. También debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda entender. Debemos brindarle información sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener información que pueda entender, llame a Servicios para Miembros. Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder las preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en otros idiomas además del español y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame al 1-844-765-5160 o escriba a Wellpoint Full Dual Advantage (HMO D-SNP) P.O. Box 61010 Virginia Beach, VA 23466-1010.
    - Para obtener información que pueda entender, llame a Servicios para Miembros. Nuestro plan cuenta con personas que pueden responder las preguntas en diferentes idiomas. También puede brindarle materiales en otros idiomas, además del español, y en formatos como letra grande, braille o audio. Puede llamar a Servicios para Miembros y pedir que le envíen los materiales en español.
    - Puede recibir este documento de forma gratuita en otros idiomas y formatos, como en letra grande, braille o audio. Llame a Servicios para Miembros al número que figura en la parte inferior de esta página. Cuando llame, indique si se trata de un pedido regular. Eso quiere decir que, todos los años, enviaremos los mismos documentos en el formato e idioma solicitados. Puede llamarnos para cambiar o cancelar el pedido regular. También puede encontrar los documentos en línea, en shop.wellpoint.com/medicare.

Si tiene dificultades para recibir información de nuestro plan debido a limitaciones de idioma o a una discapacidad, y desea presentar una queja, puede comunicarse con:

- Medicare al 1-800-MEDICARE (1-800-633-4227). Puede llamar las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048.

- NJ Medicaid al 1-800-701-0710. Los usuarios de TTY deben llamar al 1-800-701-0720.
- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos (HHS) de los Estados Unidos al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

B. Our responsibility for your timely access to covered services and drugs

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of your *Evidence of Coverage*.
    - Call your care manager or Member Services or look in the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- You have the right to a women's health specialist without getting a referral. A referral is approval from your PCP to use a provider that is not your PCP.
- You have the right to get covered services from network providers within a reasonable amount of time.
    - This includes the right to get timely services from specialists.
    - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior approval (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Evidence of Coverage*.

Chapter 9 of your *Evidence of Coverage* tells what you can do if you think you aren't getting your services or drugs within a reasonable amount of time. It also tells what you can do if we denied coverage for your services or drugs and you don't agree with our decision.

C. Our responsibility to protect your personal health information (PHI)

We protect your PHI as required by federal and state laws.

Your PHI includes information you gave us when you enrolled in our plan. It also includes your medical records and other medical and health information.

You have rights when it comes to your information and controlling how your PHI is used. We give you a written notice that tells about these rights and explains how we protect the privacy of your PHI. The notice is called the "Notice of Privacy Practice."

C1. How we protect your PHI

We make sure that no unauthorized people look at or change your records.

Except for the cases noted below, we don't give your PHI to anyone not providing your care or paying for your care. If we do, we must get written permission from you first. You, or someone legally authorized to make decisions for you, can give written permission.

Sometimes we don't need to get your written permission first. These exceptions are allowed or required by law:

- We must release PHI to government agencies checking on our plan's quality of care.
- We must release PHI by court order.
- We must give Medicare your PHI. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.

- You have the right to know if and how we share your PHI with others.

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

Below is the Notice of Privacy Practices as of June 2022.

Notice of privacy practices

Important information about your rights and our responsibilities

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

- State notice of privacy practices
- Health Insurance Portability and Accountability Act (HIPAA) notice of privacy practices
- Breast reconstruction surgery benefits

Would you like to go paperless and read this online or on your mobile app? Go to https://shop.wellpoint.com/medicare and sign up to get these notices by email.

State notice of privacy practices

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

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

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

Your personal information

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

We may receive your PI from others, such as doctors, hospitals or other insurance companies.

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

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

HIPAA notice of privacy practices

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

Your protected health information

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

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

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

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

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.

- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you don't want your PHI to be shared in these situations, visit https://shop.wellpoint.com/medicare for more information.

Sharing your PHI with you: We must give you access to your own PHI. We may also contact you about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other plans or programs for which you may be eligible, including individual coverage. We may also send you reminders about routine medical checkups and tests. You may get emails that have limited PHI, such as welcome materials. We'll ask your permission before we contact you.

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

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

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

You have the right and choice to tell us to:

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

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

Other reasons we may use or share your information:

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

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

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

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

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

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

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of your PHI, including a request for a copy of your PHI through email. Remember, there's a risk your PHI could be read by a third party when it's sent unencrypted, meaning regular email. So we will first confirm that you want to get your PHI by unencrypted email before sending it to you. We will provide you a copy of your PHI usually within 30 days of your request. If we need more time, we will let you know.
- Ask that we correct your PHI that you believe is wrong or incomplete. If someone else, such as your doctor, gave us the PHI, we'll let you know so you can ask him or her to correct it. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Send us a written request not to use your PHI for treatment, payment or health care operations activities. We may say "no" to your request, but we'll tell you why in writing.
- Request confidential communications. You can ask us to send your PHI or contact you using other ways that are reasonable. Also, let us know if you want us to send your mail to a different address if sending it to your home could put you in danger.
- Send us a written request to ask us for a list of those with whom we've shared your PHI. We will provide you a list usually within 60 days of your request. If we need more time, we will let you know.
- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for

a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see “Your rights” above). If a law requires sharing your information, we don’t have to agree to your restriction.

- Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

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

We keep your oral, written and electronic PHI safe using the right procedures, and through physical and electronic ways. These safety measures follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their jobs. Employees are also required to wear ID badges to help keep unauthorized people out of areas where your PHI is kept. Also, where required by law, our business partners must protect the privacy of data we share with them as they work with us. They’re not allowed to give your PHI to others without your written permission, unless the law allows it and it’s stated in this notice.

Potential impact of other applicable laws

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

To see more information

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

Calling or texting you

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

Complaints

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

Contact information

You may call us at the Member Services phone number on your ID card. Our representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to ask for a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We're required by law to follow the privacy notice that's in effect at this time. We may tell you about any changes to our notice through a newsletter, our website or a letter.

Effective date of this notice

The original effective date of this Notice was April 14, 2003.

Breast reconstruction surgery benefits

A mastectomy that's covered by your health plan includes benefits that comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.

- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

For details, contact your plan administrator.

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

D. Our responsibility to give you information

As a member of our plan, you have the right to get information from us about our plan, our network providers, and your covered services.

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. You can call Member Services and ask to have this information sent to you in Spanish. We can also give you information in large print, braille, data or audio CD.

If you want information about any of the following, call Member Services:

- How to choose or change plans
- Our plan, including:
    - financial information
    - how plan members have rated us
    - the number of appeals made by members
    - how to leave our plan
- Our network providers and our network pharmacies, including:
    - how to choose or change primary care providers
    - qualifications of our network providers and pharmacies
    - how we pay providers in our network

- Covered services and drugs, including:
    - services (refer to **Chapters 3 and 4** of your *Evidence of Coverage*) and drugs (refer to **Chapters 5 and 6** of your *Evidence of Coverage*) covered by our plan
    - limits to your coverage and drugs
    - rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Evidence of Coverage*), including asking us to:
    - put in writing why something is not covered
    - change a decision we made
    - pay for a bill you got

E. Inability of network providers to bill you directly

Doctors, hospitals, and other providers in our network cannot make you pay for covered services. They also cannot balance bill or charge you if we pay less than the amount the provider charged. To learn what to do if a network provider tries to charge you for covered services, refer to **Chapter 7** of your *Evidence of Coverage*.

F. Your right to leave our plan

No one can make you stay in our plan if you do not want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.
- You can get your Medicare Part D prescription drug benefits from a prescription drug plan or from another MA plan.
- Refer to **Chapter 10** of your *Evidence of Coverage:*
    - For more information about when you can join a new MA or prescription drug benefit plan.
    - For information about how you will get your NJ Medicaid benefits if you leave our plan.

G. Your right to make decisions about your health care

You have the right to full information from your doctors and other health care providers to help you make decisions about your health care.

G1. Your right to know your treatment choices and make decisions

Your providers must explain your condition and your treatment choices in a way that you can understand. You have the right to:

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we will not drop you from our plan. However, if you refuse treatment or stop taking a drug, you accept full responsibility for what happens to you.
- **Ask us to explain why a provider denied care.** You have the right to get an explanation from us if a provider denied care that you think you should get.
- **Ask us to cover a service or drug that we denied or usually don't cover.** This is called a coverage decision. **Chapter 9** of your *Evidence of Coverage* tells how to ask us for a coverage decision.

G2. Your right to say what you want to happen if you are unable to make health care decisions for yourself

Sometimes people are unable to make health care decisions for themselves. Before that happens to you, you can:

- Fill out a written form **giving someone the right to make health care decisions for you**.

- **Give your doctors written instructions** about how to handle your health care if you become unable to make decisions for yourself, including care you do **not** want.

The legal document that you use to give your directions is called an “advance directive.” There are different types of advance directives and different names for them. Examples are a living will and a power of attorney for health care.

You are not required to have an advance directive, but you can. Here’s what to do if you want to use an advance directive:

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital**.
    - The hospital will ask if you have a signed advance directive form and if you have it with you.
    - If you don’t have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

- Have your advance directive placed in your medical records.
- Change or cancel your advance directive at any time.

Call Member Services for more information.

G3. What to do if your instructions are not followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the Division of Medical Assistance and Health Services. Please visit the State of New Jersey, Department of Human Services website, www.state.nj.us/humanservices/dmahs/home/.

H. Your right to make complaints and ask us to reconsider our decisions

Chapter 9 of your *Evidence of Coverage* tells you what you can do if you have any problems or concerns about your covered services or care. For example, you can ask us to make a coverage decision, make an appeal to change a coverage decision, or make a complaint.

You have the right to get information about appeals and complaints that other plan members have filed against us. Call Member Services to get this information.

H1. What to do about unfair treatment or to get more information about your rights

If you think we treated you unfairly – and it is **not** about discrimination for reasons listed in **Chapter 11** of your *Evidence of Coverage* – or you want more information about your rights, you can call:

- Member Services.
- The SHIP program at 1-800-792-8820. For more details about the SHIP , refer to Chapter 2, Section 3.
- The Ombudsperson Program at 1-800-446-7467. For more details about this program, refer to Chapter 2 of your *Evidence of Coverage*.

Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. (You can also read or download "Medicare Rights & Protections," found on the Medicare website at www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)

You can also contact the New Jersey Medicaid program for assistance. You can call the NJ Department of Human Services, Division of Medical Assistance and Health Services at 1-800-701-0710 (TTY: 711).

I. Your responsibilities as a plan member

As a plan member, you have a responsibility to do the things that are listed below. If you have any questions, call Member Services.

- **Read the** *Evidence of Coverage* to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
    - Covered services, refer to **Chapters 3 and 4** of your *Evidence of Coverage*. Those chapters tell you what is covered, what is not covered, what rules you need to follow, and what you pay.
    - Covered drugs, refer to **Chapters 5 and 6** of your *Evidence of Coverage*.
- **Tell us about any other health or prescription drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you are a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
    - Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.
    - Make sure your doctors and other providers know about all of the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
    - Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - **If you get any services or drugs that are not covered by our plan, you must pay the full cost.** (**Note:** If you disagree with our decision to not cover

a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)

- **Tell us if you move.** If you plan to move, tell us right away. Call *your care manager or* Member Services.
  - **If you move outside of our service area, you cannot stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of your *Evidence of Coverage* tells about our service area.
  - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or prescription drug plan in your new location. We can tell you if we have a plan in your new area.
  - Tell Medicare and NJ FamilyCare your new address when you move. Refer to **Chapter 2** of your *Evidence of Coverage* for phone numbers for Medicare and NJ FamilyCare.
  - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
- **Call your care manager or Member Services for help if you have questions or concerns.**

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

Introduction

This chapter has information about your rights. Read this chapter to find out what to do if:

- You have a problem with or complaint about your plan.
- You need a service, item, or medication that your plan said it won't pay for.
- You disagree with a decision your plan made about your care.
- You think your covered services are ending too soon.

This chapter is in different sections to help you easily find what you are looking for. **If you have a problem or concern, read the parts of this chapter that apply to your situation.**

Table of Contents

A. What to do if you have a problem or concern

This chapter explains how to handle problems and concerns. The process you use depends on the type of problem you have. Use one process for **coverage decisions and appeals** and another for **making complaints**; also called grievances.

To ensure fairness and promptness, each process has a set of rules, procedures, and deadlines that we and you must follow.

A1. About the legal terms

There are legal terms in this chapter for some rules and deadlines. Many of these terms can be hard to understand, so we use simpler words in place of certain legal terms when we can. We use abbreviations as little as possible.

For example, we say:

- “Making a complaint” instead of “filing a grievance”
- “Coverage decision” instead of “organization determination”, “benefit determination”, “at-risk determination”, or “coverage determination”
- “Fast coverage decision” instead of “expedited determination”
- “Independent Review Organization” (IRO) instead of “Independent Review Entity” (IRE)

Knowing the proper legal terms may help you communicate more clearly, so we provide those too.

B. Where to get help

B1. For more information and help

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

Help from the State Health Insurance Assistance Program (SHIP)

You can call the SHIP. The SHIP counselors can answer your questions and help you understand what to do about your problem. The SHIP is not connected with us or with any

insurance company or health plan. The SHIP has trained counselors in every county, and services are free. The SHIP phone number is 1-800-792-8820 (TTY: 711).

Help and information from Medicare

For more information and help, you can contact Medicare. Here are two ways to get help from Medicare:

- Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
- Visit the Medicare website (www.medicare.gov).

Help and information from the NJ Department of Human Services, Division of Medical Assistance and Health Services (the New Jersey Medicaid program)

You can get help and information from the Division of Medical Assistance and Health Services (the New Jersey Medicaid program) by calling 1-800-701-0710 (TTY: 711). Their website can be found at www.state.nj.us/humanservices/dmahs/.

C. Understanding Medicare and NJ FamilyCare complaints and appeals in our plan

You have Medicare and NJ FamilyCare. Information in this chapter applies to **all** of your Medicare and NJ FamilyCare benefits. This is sometimes called an “integrated process” because it combines, or integrates, Medicare and NJ FamilyCare processes.

Sometimes Medicare and NJ FamilyCare processes cannot be combined. In those situations, you use one process for a Medicare benefit and another process for an NJ FamilyCare benefit. **Section F4** explains these situations.

D. Problems with your benefits

If you have a problem or concern, read the parts of this chapter that apply to your situation. The following chart helps you find the right section of this chapter for problems or complaints.

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 they are covered, and problems about payment for medical care or prescription drugs.	
Yes. My problem is about benefits or coverage. Refer to **Section E,** "Coverage decisions and appeals."	**No.** My problem is not about benefits or coverage. Refer to **Section K**, "How to make a complaint."

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage. It also includes problems with payment.

E1. Coverage decisions

A coverage decision is a decision we make about your benefits and coverage for your medical services or drugs. For example, if your plan network provider refers you to a medical specialist outside of the network, this referral is considered a favorable decision unless either your network provider can show that you received a standard denial notice for this medical specialist, or the referred service is never covered under any condition (refer to **Chapter 4, Section H** of your *Evidence of Coverage).*

You or your doctor can also contact us and ask for a coverage decision. You or your doctor may be unsure whether we cover a specific medical service or if we may refuse to provide medical care you think you need. **If you want to know if we will cover a medical service before you get it, you can ask us to make a coverage decision for you.**

We make a coverage decision whenever we decide what is covered for you. In some cases, we may decide a service or drug is not covered or is no longer covered for you by Medicare or NJ FamilyCare. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

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 if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

When we complete the review, we give you our decision. Under certain circumstances, explained later in this chapter, you can ask for an expedited or “fast coverage decision” or “fast appeal” of a coverage decision.

If we say **No** to part or all of what you asked for, we will send you a letter. If your problem is about coverage of a Medicare medical service or item or Part B drugs, the letter will tell you that we sent your case to the Independent Review Organization (IRO) for a Level 2 Appeal. If your problem is about coverage of a Medicare Part D or Medicaid service or item, the letter will tell you how to file a Level 2 Appeal yourself. Refer to **Section F4** for more information about Level 2 Appeals. If your problem is about coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 Appeals. If your problem is about a coverage of a service or item covered by both Medicare and Medicaid, the letter will give you information regarding both types of Level 2 appeals.

If you are not satisfied with the Level 2 Appeal decision, you may be able to go through additional levels of appeal.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- The State Health Insurance Assistance Program (SHIP), which can be reached at 1-800-792-8820 (TTY: 711).
- **Your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member**. You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.

- **A lawyer**. You have the right to a lawyer, but **you are not required to have a lawyer** to ask for a coverage decision or make an appeal.
    - Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

Fill out the Appointment of Representative form if you want a lawyer or someone else to act as your representative. The form gives someone permission to act for you.

Call Member Services at the numbers at the bottom of the page and ask for the "Appointment of Representative" form. You can also get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf. **You must give us a copy of the signed form.**

E4. Which section of this chapter can help you

There are four situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give details for each one in a separate section of this chapter. Refer to the section that applies:

- **Section F**, "Medical care"
- **Section G**, "Medicare Part D prescription drugs"
- **Section H**, "Asking us to cover a longer hospital stay
- **Section I**, "Asking us to continue covering certain medical services (This section only applies to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.)

If you're not sure which section to use, call Member Services at the numbers at the bottom of the page.

F. Medical care

This section explains what to do if you have problems getting coverage for medical care or if you want us to pay you back for your care.

This section is about your benefits for medical care and services that are described in **Chapter 4** of your *Evidence of Coverage*. We generally refer to "medical care coverage" or "medical care" in the rest of this section. The term "medical care" includes medical services and items,

behavioral health services, and MLTSS services, as well as Medicare Part B prescription drugs which are drugs administered by your doctor or health care professional. Different rules may apply to a Medicare Part B prescription drug. When they do, we explain how rules for Medicare Part B prescription drugs differ from rules for medical services and items.

F1. Using this section

This section explains what you can do in any of the five following situations:

1. You think we cover medical care you need but are not getting.

   What you can do: You can ask us to make a coverage decision. Refer to **Section F2**.

2. We didn't approve the medical care your doctor or other health care provider wants to give you, and you think we should.

   What you can do: You can appeal our decision. Refer to **Section F3**.

3. You got medical care that you think we cover, but we will not pay.

   What you can do: You can appeal our decision not to pay. Refer to **Section F5**.

4. You got and paid for medical care you thought we cover, and you want us to pay you back.

   What you can do: You can ask us to pay you back. Refer to **Section F5**.

5. We reduced or stopped your coverage for certain medical care, and you think our decision could harm your health.

   What you can do: You can appeal our decision to reduce or stop the medical care. Refer to **Section F4**.

   - If the coverage is for hospital care, home health care, skilled nursing facility care, or CORF services, special rules apply. Refer to **Section H** or **Section I** to find out more.
   - For all other situations involving reducing or stopping your coverage for certain medical care, use this section (**Section F**) as your guide.

F2. Asking for a coverage decision

> When a coverage decision involves your medical care, it's called an **"integrated organization determination**.

You, your doctor, or your representative can ask us for a coverage decision by:

- Calling: 1-844-765-5160*,* TTY: *711*.
- Faxing: 1-877-664-1504.
- Writing:Wellpoint Coverage Decisions
  P.O. Box 61010
  Virginia Beach, VA 23466-1010

Standard coverage decision

When we give you our decision, we use the "standard" deadlines unless we agree to use the "fast" deadlines. A standard coverage decision means we give you an answer about a**:**

- Medical service or item within 14 calendar days after we get your request.
- Medicare Part B prescription drug within 72 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if you ask for more time or if we need more information that may benefit you (such as medical records from out-of-network providers). If we take extra days to make the decision, we will tell you in writing. **We can't take extra days if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we 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 making a complaint, including a fast complaint, refer to **Section K.**

Fast coverage decision

> The legal term for "fast coverage decision" is "**expedited determination**."

When you ask us to make a coverage decision about your medical care and your health requires a quick response, ask us to make a "fast coverage decision." A fast coverage decision means we will give you an answer about a:

- Medical service or item within 72 hours after we get your request.
- Medicare Part B prescription drug within 24 hours after we get your request.

For a medical item or service, we can take up to 14 more calendar days if we find information that may benefit you is missing (such as medical records from out-of-network providers) or if you need time to get us information for the review. If we take extra days to make the decision, we will tell you in writing. **We can't take extra time if your request is for a Medicare Part B prescription drug.**

If you think we should **not** take extra days to make the coverage decision, you can make a "fast complaint" about our decision to take extra days. For more information about making a complaint, including a fast complaint, refer to **Section K**. We will call you as soon as we make the decision.

To get a fast coverage decision, you must meet two requirements:

- You are asking for coverage for medical care you **did not get**. You can't ask for a fast coverage decision about payment for medical care you already got.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

We automatically give you a fast coverage decision if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast coverage decision.

- If we decide that your health doesn't meet the requirements for a fast coverage decision, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
    - We automatically give you a fast coverage decision if your doctor asks for it.

- How you can file a “fast complaint” about our decision to give you a standard coverage decision instead of a fast coverage decision. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we say No to part or all of your request, we send you a letter explaining the reasons.

- If we say **No**, you have the right to make an appeal. If you think we made a mistake, making an appeal is a formal way of asking us to review our decision and change it.
- If you decide to make an appeal, you will go on to Level 1 of the appeals process (refer to **Section F3**).

In limited circumstances we may dismiss your request for a coverage decision, which means we won’t review the request. Examples of when a request will be dismissed include:

- if the request is incomplete,
- if someone makes the request on your behalf but isn’t legally authorized to do so, **or**
- if you ask for your request to be withdrawn.

If we dismiss a request for a coverage decision, we will send you a notice explaining why the request was dismissed and how to ask for a review of the dismissal. This review is called an appeal. Appeals are discussed in the next section.

F3. Making a Level 1 Appeal

To start an appeal, you, your doctor, or your representative must contact us. Call us at 1-844-765-5160 (TTY 711).

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-844-765-5160 (TTY 711).

- If your doctor or other prescriber asks to continue a service or item you are already getting during your appeal, you may need to name them as your representative to act on your behalf.
- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you.

You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.

- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form within 44 calendar days after getting your appeal request:
  - We dismiss your request, and
  - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 60 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> The legal term for "fast appeal" is **"expedited reconsideration."**

- If you appeal a decision we made about coverage for care that you did not get, you and/or your doctor decide if you need a fast appeal.

We automatically give you a fast appeal if your doctor tells us your health requires it. If you ask without your doctor's support, we decide if you get a fast appeal.

- If we decide that your health doesn't meet the requirements for a fast appeal, we send you a letter that says so and we use the standard deadlines instead. The letter tells you:
  - We automatically give you a fast appeal if your doctor asks for it.
  - How you can file a "fast complaint" about our decision to give you a standard appeal instead of a fast appeal. For more information about making a complaint, including a fast complaint, refer to **Section K**.

If we tell you we are stopping or reducing services or items that you already get, you may be able to continue those services or items during your appeal.

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.
- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within 10 calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
    - If you meet this deadline, you will get the service or item with no changes while your Level 1 appeal is pending.
    - You will also get all other services or items (that are not the subject of your appeal) with no changes.
    - If you do not appeal before these dates, then your service or item will not be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all information about your request for coverage of medical care.
- We check if we followed all the rules when we said **No** to your request.
- We gather more information if we need it. We may contact you or your doctor to get more information.

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 72 hours after we get your appeal**. We will give you our answer sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
    - If we need extra days to make the decision, we tell you in writing.

- If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
- If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options, starting on page 189.

- **If we say Yes to part or all of your request,** we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request,** we send your appeal to the IRO for a Level 2 Appeal.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B prescription drug you didn't get, we give you our answer **within 7 calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service**.**
  - If we need extra days to make the decision, we tell you in writing.
  - If your request is for a Medicare Part B prescription drug, we can't take extra time to make the decision.
  - If you think we should **not** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24

hours. For more information about making complaints, including fast complaints, refer to **Section K.**

- If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 appeal with the state yourself as soon as the time is up. In New Jersey, you have two options for Level 2 appeals. The first is called an IURO appeal. The IURO is the state's Independent Utilization Review Organization. The other option is called a Fair Hearing. **Section F4** includes a detailed explanation of these two options, starting on page 189.

If we say Yes to part or all of your request, we must authorize or provide the coverage we agreed to provide within 30 calendar days, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug, after we get your appeal.

If we say **No** to part or all of your request, **you have additional appeal rights:**

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal.
- If your problem is about coverage of a NJ FamilyCare service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

If we say **No** to part or all of your Level 1 Appeal, we send you a letter. This letter tells you if Medicare, NJ FamilyCare, or both programs usually cover the service or item.

- If your problem is about a service or item that Medicare usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that NJ FamilyCare usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.

- If your problem is about a service or item that **both Medicare and NJ FamilyCare** may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 Appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Refer to **Section F3** for information about continuing your benefits during Level 1 Appeals.

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by NJ FamilyCare, your benefits for that service continue if you submit a Level 2 Appeal within 10 calendar days after getting our decision letter.

When your problem is about a service or item Medicare usually covers

The IRO reviews your appeal. It's an independent organization hired by Medicare.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity"**, sometimes called the **"IRE"**.

- This organization isn't connected with us and isn't a government agency. Medicare chose the company to be the IRO, and Medicare oversees their work.
- We send information about your appeal (your "case file") to this organization. You have the right to a free copy of your case file.
- You have a right to give the IRO additional information to support your appeal.
- Reviewers at the IRO take a careful look at all information related to your appeal.

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The

IRO can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to us at Level 1, you automatically get a standard appeal at Level 2.
- If your request is for a medical item or service, the IRO must give you an answer to your Level 2 Appeal **within 30 calendar days** of getting your appeal.
- If your request is for a Medicare Part B prescription drug, the IRO must give you an answer to your Level 2 Appeal **within 7 calendar days** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

The IRO gives you their answer in writing and explains the reasons.

- **If the IRO says Yes to part or all of a request for a medical item or service,** we must:
  - Authorize the medical care coverage **within 72 hours, or**
  - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
  - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests**.
- **If the IRO says Yes to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute:**
  - **within 72 hours** after we get the IRO's decision for **standard requests, or**
  - **within 24 hours** from the date we get the IRO's decision for **expedited requests**.

- **If the IRO says No to part or all of your appeal,** it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”
    - 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.
    - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
    - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

When your problem is about a service or item Medicaid usually covers, or that is covered by both Medicare and NJ FamilyCare

A Level 2 Appeal for services that NJ FamilyCare usually covers gives you two options. One option is an appeal with the IURO, the state’s Independent Utilization Review Organization. The second option is a Fair Hearing with the state. You must request an IURO appeal **within 60 calendar days** of the date we sent the decision letter on your Level 1 Appeal. You must ask for a Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

How do I request an IURO appeal?

- The Independent Utilization Review Organization (IURO) is an independent organization that is hired by the State of New Jersey’s Department of Banking and Insurance (DOBI). This organization is not connected with us, and it is not a government agency. This organization is chosen by the DOBI to serve as an independent reviewer for medical appeals, and the DOBI administers the IURO appeal process. A review by the IURO is also sometimes called an “IURO appeal” or an “External Appeal”.

- The IURO will typically not review cases based on the following services:
  - assisted living program
  - assisted living services - when the denial is not based on medical necessity
  - caregiver/participant training
  - chore services
  - community transition services
  - home based supportive care
  - home-delivered meals
  - personal care assistance (PCA)
  - respite (daily and hourly)
  - social day care
  - structured day program -- when the denial is not based on medical necessity
  - supported day services -- when the denial is not based on the diagnosis of TBI
- The IURO appeal process is optional. You can request an IURO appeal, and wait to receive the IURO's decision, before you request a Fair Hearing. Or, you can request an IURO appeal and a Fair Hearing at the same time (the requests are made to two different organizations). **You are not required to request an IURO appeal before requesting a Fair Hearing.**
- You can request an IURO appeal yourself, or it can be requested by your Authorized Representative (which includes your provider, if they are acting on your behalf with your written consent).
- You can request an IURO appeal by filling out the External Appeal Application form. A copy of the External Appeal Application form will be sent to you with the decision letter for your Level 1 Appeal. You must send this form to the following address **within 60 calendar days** of the date we sent the decision letter on your Level 1 Appeal:

Maximus Federal – NJ IHCAP

3750 Monroe Avenue, Suite 705

Pittsford, New York 14534

You may also fax the form to **585-425-5296**, or email a completed copy of the form to Stateappealseast@maximus.com.

- If you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your IURO appeal, you must request the IURO appeal **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.
- If the IURO reviews your case, it will reach a decision **within 45 calendar days** (or sooner, if your medical condition makes it necessary). If your IURO appeal is a "fast" appeal, the IURO will reach a decision **within 48 hours**.
- If you have questions about the IURO appeal process and/or need assistance with your application, you can call the New Jersey Department of Banking and Insurance toll-free at 1-888-393-1062 or 609-777-9470.

How do I request a Fair Hearing?

- You must ask for a Fair Hearing in writing **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.
- If you ask for an expedited or "fast" Fair Hearing, and you meet all of the requirements for a "fast" hearing, a decision will be made within 72 hours of the agency's receipt of your hearing request.
- However**,** if you are appealing because we told you we were going to stop or reduce services or items that you were already getting and you want to keep those services or items during your Fair Hearing, you must request that your benefits be continued **in writing** on your Fair Hearing request, and you must send your request **within 10 calendar days** of the date on the decision letter for your Level 1 appeal.

Or, if you asked for an IURO appeal and received an adverse decision before requesting a Fair Hearing, you must send this written request **within 10 calendar days** of the date on the letter informing you of the adverse decision on your IURO appeal.

Please note that if you ask to have your services or items continue during a Fair Hearing and the final decision is not in your favor, you may be required to pay for the cost of the services or items.

The Fair Hearing office gives you their decision in writing and explain the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service**,** we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we should not approve your request (or part of your request) for coverage for medical care. This is called “upholding the decision” or “turning down your appeal.”

If the IRO or Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO,** you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We do not allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You are never required to pay the balance of any bill.

If you get a bill for covered services and items, send the bill to us. You should not pay the bill yourself. We will contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information*,* refer to **Chapter 7** of your *Evidence of Coverage*. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you are asking for a coverage decision. We will check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we will send you the payment for the service or item within 60 calendar days after we get your request.
- If you haven't paid for the service or item yet, 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 service or item is not covered or you did not follow all the rules, we will send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.
- If you ask us to pay you back for medical care you got and paid for yourself, you can't ask for a fast appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We will send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment 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 to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we should not approve your request. This is called "upholding the decision" or "turning down your appeal." You will get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and NJ FamilyCare usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4**, starting on page <*insert page number*>, for more information.

G. Medicare Part D prescription drugs

Your benefits as a member of our plan include coverage for many prescription drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that NJ FamilyCare may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of your *Evidence of Coverage* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:
  - cover a Medicare Part D drug that is not on our plan's Drug List or
  - set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's Drug List but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

> An initial coverage decision about your Medicare Part D drugs is called a **"coverage determination."**

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	**You can ask us for a coverage decision.**	**You can ask us to pay you back.** (This is a type of coverage decision.)	**You can make an appeal.** (This means you ask us to reconsider.)
Start with **Section G2**, then refer to **Sections G3 and G4**.	Refer to **Section G4**.	Refer to **Section G4**.	Refer to **Section G5**.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an "exception." 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 needs to explain the medical reasons why you need the exception.

> Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **"formulary exception."**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug that is not on our Drug List**

2. **Removing a restriction for a covered drug**

   - Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Evidence of Coverage* for more information).

   - Extra rules and restrictions for certain drugs include:

     - Being required to use the generic version of a drug instead of the brand name drug.

     - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called “prior authorization (PA).”

     - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called “step therapy.”

     - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

   - Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn’t cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar 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 exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-844-765-5160 (TTY 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Evidence of Coverage*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

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

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
    - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
    - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

> An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **"redetermination".**

- Start your **standard** or **fast appeal** by calling 1-844-765-5160 (TTY 711), writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 60 calendar days** from the date on the letter we sent to tell you our decision.

- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

If your health requires it, ask for a fast appeal.

> A fast appeal is also called an **"expedited redetermination."**

- If you appeal a decision we made about a drug you didn't get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed 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 at Level 1

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
    - We give you our answer sooner if your health requires it.
    - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within 7 calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
  - If we don't give you a decision within 7 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
  - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

> The formal name for the "Independent Review Organization" (IRO) is the **"Independent Review Entity",** sometimes called the **"IRE".**

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO **in writing** and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO . The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your "case file". **You have the right to a free copy of your case file**.
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

If your health requires it, ask the IRO for a fast appeal.

- If they agree to a fast appeal, they must give you an answer **within 72 hours** after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage **within 24 hours** after getting the IRO's decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- **within 7 calendar days** after they get your appeal for a drug you didn't get.

- **within 14 calendar days** after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
    - Decide if you want to make a Level 3 Appeal.
    - Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of your *Evidence of Coverage.*

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you 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.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. 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.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
    - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
    - Be a part of any decisions about the length of your hospital stay.
    - Know where to report any concerns you have about the quality of your hospital care.
    - Appeal if you think you're being discharged from the hospital too soon.

- **Sign the notice** to show that you got it and understand your rights.
    - You or someone acting on your behalf can sign the notice.
    - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- 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.
- Visit www.cms.gov/Medicare/Medicare-General-Information/BNI.

H2. Making a Level 1 Appeal

If you want us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In New Jersey, the QIO is Livanta. Call them at 1-866-815-5440 (TTY: 1-866-868-2289). Contact information is also in the notice, "An Important Message from Medicare about Your Rights," and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO's decision about your appeal.

- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.
- **If you miss the deadline** for contacting the QIO about your appeal, appeal to our plan directly instead. Refer to **Section G4** for information about making an appeal to us.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY: 711).

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

> The legal term for **"fast review"** is **"immediate review"** or **"expedited review."**

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that's medically appropriate for you.

> The legal term for this written explanation is the **"Detailed Notice of Discharge."** You can get a sample by calling Member Services at the numbers at the bottom of the page 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 refer to a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-866-815-5440 (TTY: 1-866-868-2289).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.

- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

H4. Making a Level 1 Alternate Appeal

The deadline for contacting the QIO for a Level 1 Appeal is within 60 days or no later than your planned hospital discharge date. If you miss the Level 1 Appeal deadline, you can use an "Alternate Appeal" process.

Contact Member Services at the numbers at the bottom of the page and ask us for a "fast review" of your hospital discharge date.

> The legal term for "fast review" or "fast appeal" is **"expedited appeal".**

- We look at all of the information about your hospital stay.
- We check that the first decision was fair and followed the rules.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need to be in the hospital after the discharge date.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.
- We pay you back for the costs of care you got since the date when we said your coverage would end.

If we say **No** to your fast appeal:

- We agree that your planned discharge date was medically appropriate.
- Our coverage for your inpatient hospital services ends on the date we told you.
- We will not pay any of the costs after this date.
- You may have to pay the full cost of hospital care you got after the planned discharge date if you continued to stay in the hospital.
- We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

H5. Making a Level 2 Alternate Appeal

We send the information for your Level 2 Appeal to the IRO within 24 hours of saying **No** to your Level 1 Appeal. We do this automatically. You don't need to do anything.

If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.

The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree that your planned hospital discharge date was medically appropriate.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we will stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing does **not** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:
    - Call Member Services at the numbers at the bottom of the page.

- Call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY: 711).

- **Contact the QIO.**
  - Refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage* for more information about the QIO and how to contact them.
  - Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal.** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.
- If you miss the deadline for contacting the QIO, you can make your appeal directly to us instead. For details about how to do that, refer to **Section I4**.

> The legal term for the written notice is **"Notice of Medicare Non-Coverage".** To get a sample copy, call Member Services at the numbers at the bottom of the page or 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. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

> The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage".**

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We will provide your covered services for as long as they are medically necessary.

If the QIO says **No** to your appeal:

- Your coverage ends on the date we told you.
- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

I3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-866-815-5440 (TTY: 1-866-868-2289).

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide coverage for the care for as long as it is medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I4. Making a Level 1 Alternate Appeal

As explained in **Section I2**, you must act quickly and contact the QIO to start your Level 1 Appeal. If you miss the deadline, you can use an “Alternate Appeal” process.

Contact Member Services at the numbers at the bottom of the page and ask us for a “fast review”.

> The legal term for “fast review” or “fast appeal” is **“expedited appeal”.**

- We look at all of the information about your case.
- We check that the first decision was fair and followed the rules when we set the date for ending coverage for your services.
- We use fast deadlines instead of standard deadlines and give you our decision within 72 hours of when you asked for a fast review.

If we say **Yes** to your fast appeal:

- We agree that you need services longer.
- We will provide your covered services for as long as the services are medically necessary.

- We agree to pay you back for the costs of care you got since the date when we said your coverage would end.
- If we say **No** to your fast appeal:
  - Our coverage for these services ends on the date we told you.
  - We will not pay any of the costs after this date.
  - You pay the full cost of these services if you continue getting them after the date we told you our coverage would end.
  - We send your appeal to the IRO to make sure we followed all the rules. When we do this, your case automatically goes to the Level 2 appeals process.

I5. Making a Level 2 Alternate Appeal

During the Level 2 Appeal:

- We send the information for your Level 2 Appeal to the IRO within 24 hours of saying No to your Level 1 Appeal. We do this automatically. You don't need to do anything.
- If you think we didn't meet this deadline, or any other deadline, you can make a complaint. Refer to **Section K** for information about making complaints.
- The IRO does a fast review of your appeal. They take a careful look at all of the information about your hospital discharge and usually give you an answer within 72 hours.

If the IRO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the IRO says **No** to your appeal:

- They agree with our decision to end your care and will not change it.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**,** we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we 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 we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
    - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional NJ FamilyCare appeals

You may also have other appeal rights if your appeal is about services or items that NJ FamilyCare usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

J3. Appeal Levels 3, 4 and 5 for Medicare Part D Drug Requests

This section may be appropriate for you if you 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 appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal**:**

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems related to quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You are unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone did not respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.

Complaint	Example
Accessibility and language assistance	• You cannot physically access the health care services and facilities in a doctor or provider's office. • Your doctor or provider does not provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). • Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office is not clean.
Information you get from us	• You think we failed to give you a notice or letter that you should have received. • You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	• You think we don't meet our deadlines for making a coverage decision or answering your appeal. • You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. • You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call 1-844-765-5160 (TTY 711).

> The legal term for a "complaint" is a **"grievance."**
>
> The legal term for "making a complaint" is **"filing a grievance."**

K2. Internal complaints

To make an internal complaint, call Member Services at 1-844-765-5160 (TTY 711). You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it **within 60 calendar** days after you had the problem you want to complain about.

- If there is anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we will respond to your complaint in writing.
- There is no filing limit for complaints related to Medicare Part C or about quality of care.

> **The legal term** for "fast complaint" is **"expedited grievance."**

If possible, we 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.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we automatically give you a "fast complaint" and respond to your complaint within 24 hours.

- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don’t agree with some or all of your complaint, we will tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/MedicareComplaintForm/home.aspx. You do not need to file a complaint with Wellpoint Full Dual Advantage (HMO D-SNP) before filing a complaint with Medicare.

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

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048. The call is free.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Linda Colón, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Jacob Javits Federal Building
26 Federal Plaza - Suite 3312
New York, NY 10278
Customer Response Center: 1-800-368-1019
Fax: 1-202-619-3818
TTY: 1-800-537-7697
Email: ocrmail@hhs.gov

You may also have rights under the Americans with Disability Act (ADA) and under other laws that apply to organizations that get Federal funding, and any other rules that apply for any other reason. You can contact the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) at 1-800-701-0710 (TTY: 711).

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO 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 learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of your *Evidence of Coverage*.

In New Jersey, the QIO is called Livanta. The phone number for Livanta is 1-866-815-5440 (TTY: 1-866-868-2289).

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and NJ FamilyCare (Medicaid) programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage*.

Table of Contents

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have NJ FamilyCare, you may be able to end your membership with our plan or switch to a different plan one time during each of the following **Special Enrollment Periods**:

- January to March
- April to June
- July to September

In addition to these three Special Enrollment periods, you may end your membership in our plan during the following periods each year:

- The **Annual Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- The **Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you are eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for NJ FamilyCare or Extra Help changed, **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to change your plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. Your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), at 1-800-792-8820 (TTY 711).

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of your *Evidence of Coverage* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can enroll in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you have not selected a separate 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 Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart on page 230.

C. How to get Medicare and NJ FamilyCare services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below. By choosing one of these options, you automatically end your membership in our plan.

1. You can change to:	Here is what to do:
Another Medicare health plan	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. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711). **OR** Enroll in a new Medicare plan. You are automatically disenrolled from our Medicare plan when your new plan's coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Wellpoint for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another dual eligible special needs plan (D-SNP) plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: 711).

2. You can change to:	**Here is what to do:**
Original Medicare with a separate Medicare prescription drug plan	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. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711). **OR** Enroll in a new Medicare prescription drug plan. You are automatically disenrolled from our plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Wellpoint for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: 711).

3. You can change to: **Original Medicare without a separate Medicare prescription drug plan** **NOTE:** 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 tell Medicare you do not want to join. You should only drop prescription drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the New Jersey State Health Insurance Asst. Program at 1-800-792-8820, Monday through Friday from 8:00 a.m. to 5:00 p.m. For more information or to find a local New Jersey State Health Insurance Asst. Program office in your area, please visit http://www.state.nj.us/humanservices/doas/services/ship/.	**Here is what to do:** 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. If you need help or more information: • Call the State Health Insurance Assistance Program (SHIP) at 1-800-792-8820 (TTY 711). You are automatically disenrolled from our plan when your Original Medicare coverage begins. If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Wellpoint for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: 711).

C2. Your NJ FamilyCare services

If you disenroll from this plan and make any of the choices listed in the chart, you will be enrolled into our affiliated NJ FamilyCare plan, Wellpoint for your NJ FamilyCare benefits. Your new coverage will begin on the first day of the following month. This will happen automatically, unless you have chosen to enroll in another D-SNP plan or if you voluntarily choose a different NJ FamilyCare plan. If you wish to select a different NJ FamilyCare plan, you can call NJ FamilyCare at 1-800-701-0710 (TTY: 711).

D. Your medical services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Medicaid coverage begins. During this time, you keep getting your prescription drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you are hospitalized on the day that your membership in Wellpoint Full Dual Advantage (HMO D-SNP) ends, our plan will cover your hospital stay until you are discharged. This will happen even if your new health coverage begins before you are discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there is a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- The Centers for Medicare & Medicaid Services (CMS) may disenroll you if it is determined that you are not eligible for the program.
- If you move out of our service area.
- If you are away from our service area for more than six months.

  - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for prescription drugs.
- If you are not a United States citizen or are not lawfully present in the United States.
  - You must be a United States citizen or lawfully present in the United States to be a member of our plan.
  - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
  - We must disenroll you if you don't meet this requirement.

If you are within our plan's three month period of deemed continued eligibility, we will continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, Medicaid-only benefits may not be covered by our plan. To find out if a benefit is Medicaid-only, and/or to find out if it will be covered, you can call Member Services at 1-844-765-5160 (TTY 711). All of your Medicare services, including Medicare Part D prescription drugs, will continue to be covered at $0 cost sharing (no copayments, coinsurance, or deductibles) during the period of deemed continued eligibility.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- 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.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, **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.

G. Your 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 refer to **Chapter 9** of your *Evidence of Coverage* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of your *Evidence of Coverage.*

Table of Contents

A. Notice about laws

Many laws apply to this *Evidence of Coverage*. These laws may affect your rights and responsibilities even if the laws are not included or explained in the *Evidence of Coverage*. The main laws that apply are federal laws about the Medicare and NJ FamilyCare (Medicaid) programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights. Please call 1-833-NJDCR4U (1-833-653-2748) (TTY: 711) or email NJDCR4U@njcivilrights.gov.
- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and NJ FamilyCare as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that NJ FamilyCare is the payer of last resort.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Evidence of Coverage* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Evidence of Coverage* explains appeals, including how to make an appeal.

Behavioral Health: An all-inclusive term referring to mental health and substance use disorders.

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care manager: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to “Individualized Care Plan.”

Care team: Refer to “Interdisciplinary Care Team.”

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Evidence of Coverage* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services. **Chapter 9** of your *Evidence of Coverage* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you are a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded Services: Services that are not covered by this health plan.

Extra Help: Medicare program that helps people with limited incomes and resources reduce Medicare Part D prescription drug costs, such as premiums, deductibles, and copays. Extra Help is also called the “Low-Income Subsidy”, or “LIS”.

***Evidence of Coverage* and Disclosure Information:** This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It’s usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care managers to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It’s used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don’t need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don’t have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We are required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you for services. Call Member Services if you get any bills you don’t understand.

Because we pay the entire cost for your services, you do **not** owe any cost-sharing. Providers should not bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity.**

Individualized Care Plan (ICP or Care Plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Interdisciplinary Care Team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs **(Drug List):** A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Managed Long-term services and supports (MLTSS): Managed Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. MLTSS include Community-Based Services and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

NJ FamilyCare: This is the name of New Jersey's Medicaid program. NJ FamilyCare is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs 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 managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare- Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program "Part D" for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Evidence of Coverage* for more information.

Member (member of our plan, or plan member): A person with Medicare and Medicaid who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Evidence of Coverage* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them "network pharmacies" because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: "Provider" is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them "network providers" when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you're a member of our plan, you must use network providers to get covered services. Network providers are also called "plan providers".

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of your *Evidence of Coverage*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called "coverage decisions". **Chapter 9** of your *Evidence of Coverage* explains coverage decisions.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.

- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or **Out-of-network facility:** A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan. **Chapter 3** of your *Evidence of Coverage* explains out-of-network providers or facilities.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They 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 use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of your *Evidence of Coverage* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Evidence of Coverage*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that 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 doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Evidence of Coverage* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes alternative drugs that may be used for the same health condition as a given drug and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of your *Evidence of Coverage*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident or major operation. Refer to **Chapter 4** of your *Evidence of Coverage* to learn more about rehabilitation services.

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 generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

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 (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

State Fair Hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State Fair Hearing. If the State Fair Hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.

Wellpoint Full Dual Advantage (HMO D-SNP) Member Services

Type	Details
CALL	1-844-765-5160 Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30 Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30
WRITE	Wellpoint P.O. Box 659403 San Antonio, TX 78265-9714
WEBSITE	https://shop.wellpoint.com/medicare