Anthem

January 1 – December 31, 2025

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Anthem Veteran (PPO)

This document gives you the details about your Medicare health care coverage from January 1 – December 31, 2025. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Customer Service at 1-855-690-7798. (TTY users should call 711). Hours are 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. This call is free.

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

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

Benefits and/or copayments or coinsurance may change on January 1, 2026.

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

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

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

2025 Evidence of Coverage

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CHAPTER 1:

Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Anthem Veteran (PPO), which is a Medicare PPO

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

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

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

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

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

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

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

If you are confused, concerned, or just have a question, please contact Customer Service.

Section 1.3 Legal information about the *Evidence of Coverage*

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

The contract is in effect for months in which you are enrolled in Anthem Veteran (PPO) between January 1, 2025 and December 31, 2025.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Anthem Veteran (PPO) after December 31, 2025. We can also choose to stop offering the plan in your service area, after December 31, 2025.

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the plan service area for Anthem Veteran (PPO)

Anthem Veteran (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Missouri: Adair, Audrain, Barry, Barton, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Christian, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Hickory, Howard, Howell, Iron, Jasper, Jefferson, Knox, Laclede, Lawrence, Lewis, Lincoln, Linn, Macon, Madison, Maries, Marion, McDonald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St. Charles, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stoddard, Stone, Sullivan, Taney, Texas, Warren, Washington, Wayne, Webster, and Wright.

If you plan to move out of the service area, you cannot remain a member of this plan. Please contact Customer Service to see if we have a plan in your new area. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

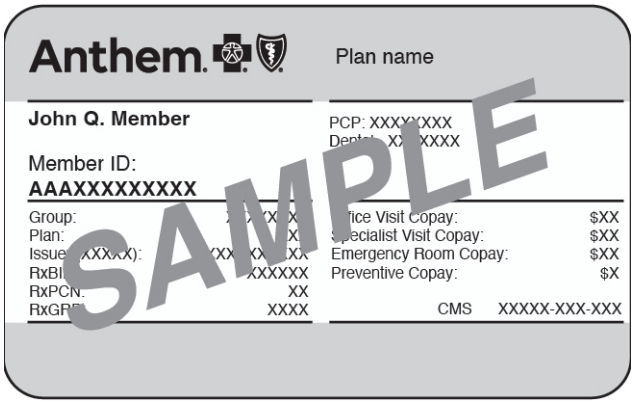
Section 2.3 U.S. Citizen or Lawful Presence

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

SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

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



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

If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2 Provider Directory

The *Provider Directory* lists our current network providers and durable medical equipment suppliers.

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

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

The most recent list of providers and suppliers is available on our website at www.anthem.com.

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

SECTION 4 Your monthly costs for Anthem Veteran (PPO)

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Optional Supplemental Benefit Premium (Section 4.3)

Medicare Part B premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2025* handbook, the section called *2025 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.1 Plan premium

You do not pay a separate monthly plan premium for Anthem Veteran (PPO).

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

As a member of our plan, you are eligible for a reduction in your Medicare Part B premium up to $70.00. The reduction is set up by Medicare and administered through Social Security Administration (SSA). Depending on how you pay your Medicare Part B premium, your reduction may be credited to your Social

Security check or credited on your Medicare Part B premium statement. Reductions may take several months to be issued.

Please be aware that should you disenroll from Anthem Veteran (PPO) your Part B premium reduction will end on the effective date of disenrollment. The Social Security Administration may take several months to complete the necessary processing. If your Part B premium is automatically deducted from your monthly Social Security check, any Part B premium reductions you receive after the effective date of disenrollment will be deducted from your subsequent monthly Social Security check.

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

Section 4.3 Optional Supplemental Benefit Premium

If you signed up for extra benefits, also called *optional supplemental benefits*, then you pay an additional premium each month for these extra benefits. See Chapter 4, Section 2.2 for details.

- Preventive Dental Package: $17.00 additional monthly premium.
- Dental and Vision Package: $26.00 additional monthly premium.
- Enhanced Dental and Vision Package: $55.00 additional monthly premium.

SECTION 5 More information about your monthly premium

Section 5.1 Can we change your monthly plan premium during the year?

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

SECTION 6 Keeping your plan membership record up to date

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider (PCP)/Independent Physician Association (IPA).

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

information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study (**Note**: You are not required to tell your plan about the clinical research studies you intend to participate in, but we encourage you to do so).

If any of this information changes, please let us know by calling Customer Service.

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

SECTION 7 How other insurance works with our plan

Other insurance

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Customer Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

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

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

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

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

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

CHAPTER 2:

Important phone numbers and resources

SECTION 1 Anthem Veteran (PPO) contacts (How to contact us, including how to reach Customer Service)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Anthem Veteran (PPO) Customer Service. We will be happy to help you.

Method	Customer Service – Contact Information
CALL	1-855-690-7798 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Customer Service 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.
FAX	1-877-664-1504
WRITE	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com

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

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

complaints)).

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-855-690-7798 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
TTY	711 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
FAX	1-877-664-1504
WRITE	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	https://shop.anthem.com/medicare

Method	Appeals for Medical Care – Contact Information
CALL	1-855-690-7798 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
TTY	711 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

Method	Appeals for Medical Care – Contact Information
FAX	1-888-458-1406
WRITE	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
WEBSITE	https://shop.anthem.com/medicare

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

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

Method	Complaints About Medical Care – Contact Information
CALL	1-855-690-7798 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.
TTY	711 Calls to this number are free. Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
FAX	1-888-458-1406
WRITE	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040

Method	Complaints About Medical Care – Contact Information
MEDICARE WEBSITE	You can submit a complaint about Anthem Veteran (PPO) directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill, see Chapter 5 *(Asking us to pay our share of a bill you have received for covered medical services)*.

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

Method	Payment Requests for Medical Care – Contact Information
CALL	1-855-690-7798 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.
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	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com

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

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

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

Method	Medicare – Contact Information
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

Method	Medicare – Contact Information
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes documents you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about Anthem Veteran (PPO): • **Tell Medicare about your complaint:** You can submit a complaint about Anthem Veteran (PPO) directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website and review the information with you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Missouri, the SHIP is called Missouri State Health Insurance Assistance Program (SHIP).

Missouri State Health Insurance Assistance Program (SHIP) is an independent (not connected with any insurance company or health plan) state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Missouri State Health Insurance Assistance Program (SHIP) counselors can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. Missouri State Health Insurance Assistance Program (SHIP) counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

METHOD TO ACCESS SHIP and OTHER RESOURCES:

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

Method	Missouri State Health Insurance Assistance Program (SHIP) – Contact Information
CALL	1-800-390-3330 9 a.m. - 4 p.m. local time, Monday - Friday
TTY	711
WRITE	State Health Insurance Assistance Program 601 W Nifong Blvd, Suite 3A Columbia, MO 65203
WEBSITE	http://missouriclaim.org/

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Missouri, the Quality Improvement Organization is called Livanta - Missouri's Quality Improvement Organization.

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

You should contact Livanta - Missouri's Quality Improvement Organization in any of these situations:

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

Method	Livanta - Missouri's Quality Improvement Organization – Contact Information
CALL	1-888-755-5580 9 a.m. - 5 p.m. local time, Monday - Friday; 11 a.m. - 3 p.m. local time, Saturday - Sunday
TTY	1-888-985-9295 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta/Missouri's Quality Improvement Organization 10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	https://www.livantaqio.com

SECTION 5 Social Security

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

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

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

Method	Social Security– Contact Information
CALL	1-800-772-1213 Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8:00 am to 7:00 pm, Monday through Friday.
WEBSITE	https://www.ssa.gov

SECTION 6 Medicaid

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. The programs offered through Medicaid help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and its programs, contact MO HealthNet (Missouri Medicaid).

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

SECTION 7 How to contact the Railroad Retirement Board

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. If you press "0", you may speak with an RRB representative from 9:00 am to 3:00 pm, Monday through Friday. The RRB is closed on Federal Holidays. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

SECTION 8 Do you have group insurance or other health insurance from an employer?

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Customer Service if you have any questions. You can ask about your (or your spouse or domestic partner's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Customer Service are printed on the back cover of this document.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3:

Using the plan for your medical services

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

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

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

Section 1.1 What are network providers and covered services?

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

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

As a Medicare health plan, Anthem Veteran (PPO) must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

Anthem Veteran (PPO) will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this document).
- **The care you receive is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an

out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the *Provider Directory* .
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- Please note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

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

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

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

- When you become a member of our plan, you may choose a plan provider to be your Primary Care Provider (PCP). Your PCP is a physician, Nurse Practitioner, or Physician Assistant who meets state requirements and is trained to give you basic medical care. PCPs are licensed and credentialed. Your PCP will provide most of your care and will help you arrange or coordinate most other care you need.
- Providers who practice in any of the following medical fields are considered PCPs:
  - General Practice
  - Family Medicine
  - Internal Medicine
  - Pediatrics
  - Geriatrics
- You will usually see your PCP first for most of your routine health care needs. Your PCP may help arrange for most other services, including X-rays, laboratory tests and hospital care.

How do you choose your PCP?

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

If you need help finding a network provider, please call Customer Service at the number listed on your

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

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan, or you will pay more for covered services.

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

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

Section 2.2 What kinds of medical care can you get without a referral from your PCP?

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams
- Flu shots (or vaccines), COVID-19 vaccinations, Hepatitis B vaccinations, and pneumonia vaccinations
- Emergency services from network providers or from out-of-network providers
- Urgently needed plan-covered services which are services requiring immediate medical attention that are not emergencies, provided you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is temporarily

unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher. (If possible, please call Customer Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)

- This plan does not require referrals from your PCP or any network providers.

Section 2.3 How to get care from specialists and other network providers

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

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

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

You can get care from providers not in our plan for most of your benefits without getting our approval first. If you want to know if services are covered by Medicare before you get them, you can ask us. Your provider can ask us, too. This way you'll know if your care is considered medically necessary per the coverage guidelines. Again, you don't have to get our prior approval. But we may still review claims to see if they were medically necessary before we pay them. When we give our decision, we base it on two things. First there are Medicare's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option.

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we

furnish you with uninterrupted access to qualified doctors and specialists.

- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
    - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
    - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are currently undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs. You should obtain authorization from the plan prior to seeking care.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 7.

Section 2.4 How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to

participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:
    - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and if you are a pregnant woman, loss of an unborn child), loss of a limb or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital.

Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they are not part of our network.

- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Please call Customer Service at the number on the back of your plan membership card.

What is covered if you have a medical emergency?

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

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

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

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

What if it wasn't a medical emergency?

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

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

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

What are urgently needed services?

A plan-covered service requiring immediate medical attention that is not an emergency is an urgently

needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flair-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

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

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: if you're traveling outside of the United States for less than six months. Prescriptions purchased outside of the country are not covered even for urgent or emergency care. Please refer to the Medical Benefits Chart in Chapter 4 for more details.

Section 3.3 Getting care during a disaster

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

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

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

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

Section 4.2 If services are not covered by our plan, you must pay the full cost

Anthem Veteran (PPO) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4 of this document. If you receive services not covered by our plan, you are responsible for paying

the full cost of services.

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

SECTION 5 How are your medical services covered when you are in a clinical research study?

Section 5.1 What is a clinical research study?

A clinical research study (also called a *clinical trial*) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically request volunteers to participate in the study.

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

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

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. 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 requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies and may be subject to prior authorization and other plan rules.

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

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

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

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

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

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation such as a provider bill to the plan. The plan would then directly pay you $10. Therefore, your net payment is $10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.) You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 Receiving Care from a Religious Non-Medical Health Care Institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for

inpatient hospital care or skilled nursing facility care.

- – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will acquire ownership of the DME items following a rental period not to exceed 13 months. Your copayment will end when you obtain ownership of the item.

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

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

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare do not count. You will have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage Anthem Veteran (PPO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Anthem Veteran (PPO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

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

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter provides a Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of Anthem Veteran (PPO). Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

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

- **Copayment** is a fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is a percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

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

- Your **in-network maximum out-of-pocket amount (MOOP)** is $6,751.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from network providers. The amounts you pay for copayments and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $6,751.00 for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or

another third party).

- Your **combined maximum out-of-pocket amount** is $10,000.00. This is the most you pay during the calendar year for covered Medicare Part A and Part B services received from both in-network and out-of-network providers. The amounts you pay for copayments and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart.) If you have paid $10,000.00 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to balance bill you

As a member of Anthem Veteran (PPO), an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. Providers may not add additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

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

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

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

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

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, equipment, and Part B prescription drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan may not require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called prior authorization) from Anthem Veteran (PPO).
    - Covered services that need approval in advance to be covered as in-network services are marked in the Medical Benefits Chart. You can get care from providers not in our plan for most of your benefits without getting our approval first. If you want to know if services are covered by Medicare before you get them, you can ask us. Your provider can ask us, too. This way you'll know if your care is considered medically necessary per the coverage guidelines. Again, you don't have to get our prior approval. But we may still review claims to see if they were medically necessary before we pay them. When we give our decision, we base it on two things. First there are Medicare's rules. Second there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider's recommendation.

Other important things to know about our coverage:

- For benefits where your cost sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.
- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2025* handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- If Medicare adds coverage for any new services during 2025, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

You may have more than one cost share to pay if you get more than one service at a visit. Cost share amounts for services are listed in this chart below.

If you also are treated for another condition during a preventive service visit, or if other services are billed with the preventive service, the cost-sharing for the other services will also apply. Medicare preventive services are shown with an apple in this chart.

Services that are covered for you	**What you must pay** when you get these services
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening. **Out-of-network:** **30%** coinsurance for this preventive screening if you are eligible.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance	**In-network:** **$20.00** copay for each Medicare-covered acupuncture visit. **Out-of-network:** **30%** coinsurance for each Medicare-covered acupuncture visit.

Services that are covered for you	**What you must pay** when you get these services
with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a masters or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. Prior authorization may be required.	
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. If the covered ambulance services are not for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. Prior authorization may be required.	**In- and out-of-network:** **$290.00** copay for each covered, one-way ambulance trip by ground or water. **$290.00** copay as your portion of covered charges for each air ambulance trip.
Annual routine physical exam In addition to the Welcome to Medicare exam or the annual wellness	Any costs you pay for Medicare Non-covered Services will not

Services that are covered for you	**What you must pay** when you get these services
visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases. Please note: Additional cost share may apply for additional services or testing performed during your visit as described for each service in this medical chart.	count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for one routine physical exam each calendar year. **Out-of-network:** **30%** coinsurance for one routine physical exam each calendar year.
Annual Wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	**In-network:** There is no coinsurance, copayment, or deductible for the annual wellness visit. **Out-of-network:** **30%** coinsurance for the annual wellness visit.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement. **Out-of-network:** **30%** coinsurance for each bone mass measurement.

Services that are covered for you	**What you must pay** when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	**In-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms. **Out-of-network:** **30%** coinsurance for each screening mammogram.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Prior authorization may be required.	**In-network:** **$20.00** copay for each covered therapy visit to treat you if you've had a heart condition. **Out-of-network:** **30%** coinsurance for each therapy visit to treat you if you've had a heart condition.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	**In-network:** There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. **Out-of-network:** **30%** coinsurance for each visit to lower your risk for heart disease.

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	**In-network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years. **Out-of-network:** **30%** coinsurance for cardiovascular disease testing that is covered once every five years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams. **Out-of-network:** **30%** coinsurance for each Pap and pelvic exams.
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation Visits that are covered are to adjust alignment problems with the spine. This is called manual manipulation of the spine to fix subluxation. Prior authorization may be required.	**In-network:** **$15.00** copay for each Medicare-covered visit to see a chiropractor. **Out-of-network:** **30%** coinsurance for each Medicare-covered visit to see a chiropractor.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high-risk, or 48 months after a previous flexible sigmoidoscopy for patients who are not at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy or barium enema. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or barium enema. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 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 patient not at high-risk and 45 years or older. Once at least 48 months following the last screening barium enema or screening flexible sigmoidoscopy. Colorectal cancer screening tests include a follow-up screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.	**In-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. **$0.00** copay for a biopsy or removal of tissue during a screening exam of the colon. **Out-of-network:** **30%** coinsurance for a covered screening to be sure you don't have a colon condition. **30%** coinsurance for a biopsy or removal of tissue during a screening exam of the colon.

Services that are covered for you	**What you must pay** when you get these services
Dental services - Medicare-covered In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. Prior authorization may be required.	**In-network:** For in-network Medicare-covered dental benefits, you must use a provider that is part of the Anthem Veteran (PPO) medical network. You can find these providers in the Provider Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for Medicare-covered dental services. **Out-of-network:** **$0.00** copay for Medicare-covered dental services.
Dental services - Supplemental This plan provides additional dental coverage not covered by Original Medicare. This plan covers up to a **$2,000** allowance for covered preventive and comprehensive dental services every year. Any amount not used at the end of the calendar year will expire. Our dental allowance can be used toward covered dental service, including but not restricted to: • Exams, cleanings, x-rays, deep teeth cleanings, fluoride treatments, fillings and repairs, root canals (Endodontics),	Please see Optional Supplemental Benefits in Chapter 4, Section 2.2 for more options. Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for covered preventive dental services designed to help prevent disease.

Services that are covered for you	**What you must pay** when you get these services
dental crowns (Caps), bridges and implants, dentures, extractions and other services. For more information on supplemental dental benefit limitations and exclusions, please refer to the supplemental dental section immediately following this Medical Benefits Chart. Some dental services require prior authorization to be covered. Other dental services may be subject to limitations. In order for services to be approved, they must meet our clinical and business criteria. Please contact Customer Service for further details. Prior authorization may be required.	**$0.00** copay for covered comprehensive dental services. **Out-of-network:** **20%** coinsurance for covered preventive dental services designed to help prevent disease. **50%** coinsurance for covered comprehensive dental services. After plan paid benefits for covered dental services, you are responsible for the remaining costs. This plan offers both in-network and out-of-network supplemental dental coverage. To be covered in-network, you need to use a provider that is contracted with our dental vendor to provide supplemental dental services. Care rendered by a provider that is not part of our supplemental dental network is covered as out-of-network and may result in a higher out-of-pocket cost. Benefits received out-of-network are subject to any in-network benefit maximums, limitations, exclusions and applicable

Services that are covered for you	**What you must pay** when you get these services
	medical necessity reviews. Out-of-network providers may charge more than what the plan pays, may not be willing to bill your plan and may require up front payment from you. Should your provider charge more than the plan will reimburse, you may be billed by the out-of-network provider for any differences. To submit a request form for reimbursement, you will need to provide proof of payment and an itemized receipt. For more information, call the Dental Customer Service number located on the back of your member identification card.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	**In-network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit. **Out-of-network:** **30%** coinsurance for annual depression screening.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have	**In-network:** There is no coinsurance, copayment, or deductible for the

Services that are covered for you	**What you must pay** when you get these services
any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	Medicare covered diabetes screening tests. **Out-of-network:** **30%** coinsurance for each diabetes screening.
Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions This plan covers only OneTouch® (made by LifeScan, Inc.) and ACCU-CHECK® (made by Roche Diagnostics) blood glucose test strips and glucometers. We will not cover other brands unless your provider tells us it is medically necessary. Blood glucose test strips and glucometers MUST be purchased at a network retail or our mail-order pharmacy to be covered. Lancets may be purchased at either a pharmacy or Durable Medical	**In-and out-of-network:** This plan covers one blood glucose monitor every calendar year. OneTouch® Test Strips are covered for 100 units every 30 days and up to 300 units for a 90 day supply. ACCU-CHECK® Test Strips are covered for 102 units every 30 days and up to 306 units for a 90 day supply. Lancets are covered for 100 units every 30 days and up to 300 units for a 90 day supply. **In-network:** **$0.00** copay for: • Blood glucose test strips • Lancet devices and lancets • Blood glucose monitors **$0.00** copay for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a Durable Medical Equipment (DME) provider. **$0.00** copay for covered charges

Services that are covered for you	**What you must pay** when you get these services
Equipment provider. However lancets are limited to the following manufacturers: Lifescan / Delica, Roche, Kroger and its affiliates which include Fred Meyer, King Soopers, City Market, Fry's Food Stores, Smith's Food and Drug Centers, Dillon Companies, Ralphs, Quality Food Centers, Baker, Scott's, Owen, Payless, Gerbes, Jay-C, Prodigy, and Good Neighbor. If you are using a brand of diabetic test strips or lancets 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 plan. The meter will only be filled once during the transition period. 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. 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.	for training to help you learn how to monitor your diabetes. **Out-of-network:** **30%** coinsurance for: • Blood glucose test strips • Lancet devices and lancets • Blood glucose monitors **30%** coinsurance for therapeutic shoes, including fitting the shoes or inserts. You can buy them from a Durable Medical Equipment (DME) provider. **30%** coinsurance for training to help you learn how to monitor your diabetes.
Durable medical equipment (DME) and related supplies (For a definition of Durable Medical Equipment, see Chapter 10 as well as Chapter 3, Section 7 of this document.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website www.	**In-network:** **20%** coinsurance for durable medical equipment. Your provider must get our approval for items such as powered vehicles, powered wheelchairs and related items, and wheelchairs and beds that are not standard. Your provider must also get approval for therapeutic continuous glucose monitors covered by Medicare. Medicare oxygen equipment:

Services that are covered for you	**What you must pay** when you get these services
anthem.com. If you receive a durable medical equipment item during an inpatient stay in a hospital or skilled nursing facility, the cost will be included in your inpatient claim. 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. 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. Prior authorization may be required.	**20%** coinsurance Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in Anthem Veteran (PPO) you had made 36 months of rental payments for oxygen equipment coverage, your cost sharing in Anthem Veteran (PPO) is **20%** coinsurance. You must get durable medical equipment through our approved suppliers. You cannot purchase these items from a pharmacy. **$0.00** copay for CGMs and related supplies. **Out-of-network:** **30%** coinsurance for durable medical equipment and oxygen equipment.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson	**$90.00** copay for each emergency room visit. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the

Services that are covered for you	**What you must pay** when you get these services
with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. Emergency care coverage is worldwide.	out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital. Your emergency room copay will be waived if you receive care from a primary care provider, urgent care provider, or LiveHealth Online within 24 hours prior to the emergency room visit. This plan covers emergency services 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. If you need emergency care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 1-800-810-BLUE (1-800-810-2583). Or call collect at 1-804-673-1177. We can help you 24 hours a day,

Services that are covered for you	**What you must pay** when you get these services
	seven days a week, 365 days a year. **$90.00** copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit.
Essential Extras You may choose one (1) of the supplemental benefits below. You can select your benefit(s) either via the member portal or by contacting Customer Service. For the benefit(s) to be covered, you must use an approved provider and meet any precertification criteria. You may be able to make a one-time (1) change to your initial election if you have not used any part of your benefit(s). After you select your benefit(s), you will receive a confirmation of your election(s) with benefit(s) details. If you have any questions, please contact Customer Service. The phone number is listed on the back of this document. **Assistive Devices:** The Assistive Devices benefit provides an annual spending allowance of **$500** on your Benefits Mastercard® Prepaid Card. This spending allowance can be used to buy assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more. Unused amounts expire at end of the year. The Benefits Prepaid Card is automatically loaded with the spending allowance amount. You can only pay for your own items and cannot convert the card to cash. You have a variety of convenient ways to use your benefit:	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for the one (1) Essential Extras supplemental benefit option you have chosen. You can select one (1) of these **Essential Extras:** • Assistive Devices: **$500** annual spending allowance • Dental, Vision, and Hearing Allowance: **$500** every year • Transportation: 60 one-way trips every year

Services that are covered for you	**What you must pay** when you get these services
1. Shop online on the approved vendor website 2. Shop on the approved vendor mobile app 3. Call to place an order 4. Order by mail **Note:** • Once you've used your annual spending allowance amount, you are responsible for the remaining cost of your purchases. • Any repair or replacement of items selected is limited to the manufacturer's warranty. • Items are limited to those offered by the approved vendor and are subject to availability. • Quantity limits may apply. • Installation services are not included. **Dental, Vision, and Hearing Allowance:** Dental, Vision, and Hearing Allowance benefit provides an annual spending allowance of **$500** on your Benefits Mastercard® Prepaid Card. This spending allowance can be used to pay your provider for any dental, vision and/or hearing items or services. Cosmetic procedures are not covered under this benefit. Unused amounts expire at end of the year. If your Benefits Prepaid Card is not accepted for payment or in the event of a card transaction failure, you may submit a reimbursement request along with proof of payment. Contact information is listed on the back of your Benefits Prepaid Card. A reimbursement request must be submitted within 90 days of the date of service on your receipt. The Benefits Prepaid Card is automatically loaded with the spending allowance. You can only pay for your own services and cannot convert the card to cash.	

Services that are covered for you	**What you must pay** when you get these services
Transportation: This benefit covers routine, non-emergency one-way trips (60-mile limit per one-way trip) to locations within the local service area when obtaining plan-covered services. Trips may be covered for getting to and from covered medical visits, SilverSneakers locations and visits to a pharmacy to pick up prescriptions. You can use this benefit for one-way trips or you can schedule a round trip by using two one-way trips. Short stops at a pharmacy to pick up a prescription after a covered medical visit can be made as part of the return trip and will not require a separate trip. Ask the provider/facility to call in the prescription so you have a shorter wait. When scheduling your ride, let the vendor know if you are in a wheelchair, if you need help, or if someone will be coming with you. Modes of approved transportation may include: • Taxi • Rideshare • Wheelchair Van • Public Transportation You must use the plan approved vendor and schedule trips 48 hours (excluding weekends) in advance. Please refer to the Ambulance Services section in this chart for information on non-emergency Medicare-covered ambulance services.	
Health & fitness tracker Coverage includes a fitness tracking device to track your physical activity and promote an active lifestyle.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
Limit is one device every two years provided through our contracted vendor. Please contact Customer Service for more information.	**In-network:** **$0.00** copay for Health & Fitness tracker.
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 • Personal Emergency Response System (PERS) - see Personal Emergency Response System for more details • SilverSneakers® Fitness Program - see SilverSneakers® for more details	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for health and wellness programs covered by this plan.
Healthy Meals-Post Discharge After you are discharged from an inpatient stay at a hospital or skilled nursing facility, you may qualify for nutritious, precooked, meals delivered to you at no cost. A portion of this benefit may be used to obtain meal replacement shakes. After an overnight stay at a hospital or skilled nursing facility, you may be contacted by the plan or one of its representatives, to see if you would like this benefit. Alternatively, you or your provider/case manager can contact Customer Service after your discharge and a representative will help validate that you qualify for the benefit and 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	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for up to 2 meals a day for 7 days following your discharge from the hospital or skilled nursing facility (SNF).

Services that are covered for you	**What you must pay** when you get these services
acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements.	
Hearing services - Medicare-covered Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Prior authorization may be required.	**In-network:** For in-network Medicare-covered hearing care, you must use a doctor in the Anthem Veteran (PPO) medical network. You can find them in the Provider Directory. To learn more, call the Customer Service number on the back cover of this document. **$45.00** copay for each Medicare-covered hearing exam to determine if you need medical treatment for a hearing condition. **Out-of-network:** **30%** coinsurance for each Medicare-covered hearing exam to determine if you need medical treatment for a hearing condition.
Hearing services - Supplemental This plan provides additional hearing coverage not covered by Original Medicare. This plan covers 1 routine hearing exam up to a **$59** maximum plan benefit every year. **$300** maximum plan benefit for over-the-counter hearing aids OR 1 routine hearing aid fitting evaluation and a **$2,000** maximum plan benefit for prescribed hearing aids every year. Limit	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for routine hearing exam(s). **$0.00** copay for

Services that are covered for you	**What you must pay** when you get these services
up to one pair of hearing aid(s) per year, regardless of type. OTC hearing aids are only sold in pairs and the benefit maximum is applied to the pair. The plan has negotiated rates and options through our hearing aid supplier to give you options. For your hearing aid to be covered, you must select a device from the list available through our participating hearing aid supplier. This supplier must be used for both in-network and out-of-network benefits. The supplier will send prescription hearing aids directly to your provider and Over the counter (OTC) hearing aids, directly to you. Prescribed hearing aids may require prior authorization from our hearing supplier to ensure you are fitted with the most appropriate device available under the plan. If members choose a device with non rechargeable batteries, the plan will provide a 2-year supply (up to 64 cells per hearing aid, per year) for prescription hearing aids and a 6-month supply (up to 32 cells per hearing aid, per year) for over-the counter hearing aids. To find a provider affiliated with our hearing supplier or for information on covered devices, call the Customer Service number on the back cover of this document. After plan paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost. Prior authorization may be required.	hearing aids up to the maximum plan benefit amount. Hearing aids are limited to specific devices, based on your hearing needs. **Out-of-network:** **20%** coinsurance for routine hearing exam(s). These are exams performed by a provider not in the plans supplemental hearing network. One routine hearing exam(s) every year. One hearing aid fitting/evaluation(s) is covered for prescription hearing aids every year. There is a maximum benefit coverage of **$59.00** per year for all out-of-network exams/fittings/evaluations. Benefits received out-of-network are subject to in-network benefit maximums, limitations and/or exclusions. The total in-network and out of network allowance combined cannot exceed the benefit maximum. Although you can see an out-of-network provider for your exam, you must select a device from the list available through our participating hearing aid supplier. The plan does not reimburse for devices received

Services that are covered for you	**What you must pay** when you get these services
	from other vendors under this supplemental benefit. If you use an out-of-network provider, you may be required to pay in full at the time of service and submit a request for reimbursement. To submit a request form for reimbursement, you will need to provide proof of payment and an itemized receipt. For more information, call the Customer Service number on the back cover of this document.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening. **Out-of-network:** **30%** coinsurance for each preventive HIV screening.
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:	**In-network:** **$0.00** copay for each covered visit from a home health agency. **Out-of-network:** **30%** coinsurance for each covered visit from a home health

Services that are covered for you	**What you must pay** when you get these services
• Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies Prior authorization may be required.	agency.
Home Infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters) Covered services include but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefits • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier Separately from the Home Infusion Therapy Professional Services, Home Infusion requires a Durable Medical Equipment component: • Durable Medical Equipment - the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items	**In-network:** **$0.00** copay for Home Infusion Therapy (HIT) professional services furnished by a qualified HIT supplier in the patient's home. Durable medical equipment (DME): **20%** coinsurance DME includes the external infusion pump and the related supplies by a contracted DME Provider. **20%** coinsurance for the infusion drug(s). You may see lower out-of-pocket costs for certain home infusion drugs with prices that have increased faster than the rate of inflation. **Out-of-network:** **30%** coinsurance for Home Infusion Therapy (HIT) professional services furnished

Services that are covered for you	**What you must pay** when you get these services
Prior authorization may be required.	by a qualified HIT supplier in the patient's home. **30%** coinsurance for durable medical equipment. **$0.00** copay - **30%** coinsurance for the infusion drug(s). You may see lower out-of-pocket costs for certain home infusion drugs with prices that have increased faster than the rate of inflation.
Hospice care You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You may receive care from any Medicare-certified hospice program. Your plan is obligated to help you find Medicare-certified hospice programs in the plan's service area, including those the MA organization owns, controls, or has a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care When you are admitted to a hospice you have the right to remain in your plan; if you chose to remain in your plan you must continue to pay plan premiums. For hospice services and for services that are covered by Medicare	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. **In-network:** **$0.00** copay if you get a hospice consultation by a Primary Care Provider (PCP) before you elect hospice. **$45.00** copay if you get a hospice consultation by a specialist before you elect hospice. **Out-of-network:** **30%** coinsurance if you get a

Services that are covered for you	**What you must pay** when you get these services
Part A or B and are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You will be billed Original Medicare cost sharing. For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (such as if there is a requirement to obtain prior authorization). • If you obtain the covered services from a network provider and follow the plan rules for obtaining service, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services For services that are covered by our plan but are not covered by Medicare Part A or B: The plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	hospice consultation by a Primary Care Provider (PCP) before you elect hospice. **30%** coinsurance if you get a hospice consultation by a specialist before you elect hospice.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza	**In-network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19

Services that are covered for you	**What you must pay** when you get these services
season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines 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	vaccines. You can get a flu/influenza, pneumonia or COVID-19 vaccines without asking a doctor to refer you. The shingles shot is only covered under the Part D Prescription Drug benefit. Your plan does not cover Part D prescription drugs. Please go to your prescription drug carrier for coverage. **Out-of-network:** **30%** coinsurance for each pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines.
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. This plan covers unlimited inpatient days. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	**In-network:** For covered hospital stays: Days 1-5: **$360.00** per day, per admission / Days 6-90: **$0.00** per day, per admission You pay no copay for additional inpatient hospital days. Your benefits are based on the date of admission. If you are admitted in 2025 and discharged in 2026, the 2025 copays apply until you are discharged or transferred to a skilled nursing facility.

Services that are covered for you	**What you must pay** when you get these services
• Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance use disorder services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the	The hospital should tell the plan within one business day of any emergency admission, if possible. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. Your cost share starts the day you are admitted as an inpatient in a hospital or skilled nursing facility. You pay no cost share for the day you are discharged. **Out-of-network:** For covered hospital stays: **30%** coinsurance per stay Providers not in our network should call the plan to determine coverage before elective inpatient admission.

Services that are covered for you	**What you must pay** when you get these services
Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive treatment/services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Customer Service. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please go to Chapter 7, Section 2, How to ask us to pay you back or to pay a bill you have received. • Blood - including storage and administration. Coverage 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. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare –	

Services that are covered for you	**What you must pay** when you get these services
Ask! This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. You do not pay a copay for additional inpatient mental health hospital days in an acute care general hospital. This plan covers an unlimited number of days in the psychiatric unit of an acute care general hospital. 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.	**In-network:** For covered hospital stays: Days 1-6: **$295.00** per day, per admission / Days 7-90: **$0.00** per day, per admission You pay no copay for additional inpatient hospital days. Your benefits are based on the date of admission. If you are admitted in 2025 and discharged in 2026, the 2025 copays apply until you are discharged or transferred to a skilled nursing facility. The hospital should tell the plan within one business day of any emergency admission, if possible. If you get inpatient care at an out-of-network hospital after your emergency condition is stable, your cost is the cost sharing you would pay at a network hospital. Your cost share starts the day

Services that are covered for you	**What you must pay** when you get these services
	you are admitted as an inpatient in a hospital or skilled nursing facility. You pay no cost share for the day you are discharged. **Out-of-network:** For covered hospital stays: **30%** coinsurance per stay Providers not in our network should call the plan to determine coverage before elective inpatient admission.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay This plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached your SNF coverage limit, the plan will no longer cover your stay in the hospital or SNF. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations	You must pay the full cost if you stay in a hospital or skilled nursing facility longer than your plan covers. If you stay in a hospital or skilled nursing facility longer than what is covered, this plan will still pay the cost for doctors and other medical services that are covered as listed in this document.

Services that are covered for you	**What you must pay** when you get these services
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy Prior authorization may be required.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	**In-network:** There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services. **Out-of-network:** **30%** coinsurance for each covered medical nutrition therapy visit.
Medicare Community Resource Support Need help with a specific issue? Although your plan benefits are designed to cover what Medicare would cover, as well as some additional supplemental benefits as described in this chart, you might need additional help. 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. The Medicare Community Resource Support team will assist you by providing information and education about	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for the assistance provided by the Medicare Community Resource Support team.

Services that are covered for you	**What you must pay** when you get these services
community-based services and support programs in your area. To access this benefit, call Customer Service at the number listed on the back of your ID card and ask for the Medicare Community Resource Support team.	
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	**In-network:** There is no coinsurance, copayment, or deductible for the MDPP benefit. **Out-of-network:** **30%** coinsurance for the MDPP benefit.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment • Clotting factors you give yourself by injection if you have	**In-network:** **$35.00** copay for a one-month's supply of Medicare-covered Part B Insulin Drugs. **20%** coinsurance for chemotherapy and other Medicare-covered Part B drugs. You may see lower out-of-pocket costs for certain chemotherapy and Part B drugs with prices that have increased faster than the rate of inflation. 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 are covered for you	**What you must pay** when you get these services
hemophilia • Transplant/Immunosuppressive Drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Keep in mind, Medicare drug coverage (Part D) covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Some Antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs if the same drug is available in injectable form and the Part B ESRD benefit covers it • Calcimimetic medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral	You still have to pay your portion of the cost allowed by the plan for a Part B drug whether you get it from a doctor's office or a pharmacy. **Out-of-network:** **$35.00** copay for a one-month's supply of Medicare-covered Part B Insulin Drugs. **$0.00** copay - **30%** coinsurance for covered charges for chemotherapy and other drugs covered by Medicare Part B. You may see lower out-of-pocket costs for certain chemotherapy and Part B drugs with prices that have increased faster than the rate of inflation.

Services that are covered for you	**What you must pay** when you get these services
medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retarcrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa, or Methroxy polyethylene glycol-epoetin beta Mircera®) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Parenteral and enteral nutrition (intravenous and tube feeding) Some of the Part B covered drugs listed above may be subject to step therapy. The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://shop.anthem.com/medicare We also cover some vaccines under our Part B prescription drug benefit. Prior authorization may be required.	
24/7 Nurseline As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. When you call our nurse line, you can speak directly to a registered nurse who will help answer your health-related questions. The call is toll free and the service is	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
available anytime, including weekends and holidays. Plus, your call is always confidential. Call the 24/7 Nurseline at 1-855-658-9249. TTY users should call 711.	**$0.00** copay for the Nurseline.
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	**In-network:** There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy. **Out-of-network:** **30%** coinsurance for preventive obesity screening and therapy.
Opioid Treatment Program Services Members of our plan with opioid use disorder (OUD) can receive coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use disorder counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Prior authorization may be required.	**In-network:** **$45.00** copay for Opioid Treatment Program Services. **Out-of-network:** **30%** coinsurance for Opioid Treatment Program Services.
Outpatient diagnostic tests and therapeutic services	**In-network:**

Services that are covered for you	**What you must pay** when you get these services
and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. • Other outpatient diagnostic tests Prior authorization may be required.	**$0.00** copay for each covered lab service performed in a physician's office. **$50.00** copay for each covered lab service performed in an outpatient facility department. **$50.00** copay for each covered diagnostic procedure or test at a network doctor's office. **$100.00** copay for each covered diagnostic procedure or test at a network outpatient facility. **$0.00** copay for tests to confirm chronic obstructive pulmonary disease (COPD). **20%** coinsurance for each covered radiation therapy service. **$50.00** copay for each covered X-Ray in a provider's office. **$110.00** copay for each covered X-Ray in the outpatient department of a network hospital or facility. **$90.00** copay for each covered X-ray in a freestanding radiology facility or for portable X-ray services performed in the

Services that are covered for you	**What you must pay** when you get these services
	patient's home or facility that can be considered a patient's home. **$180.00** copay for each visit for the following Medicare-covered diagnostic radiology services: computed tomography (CT), magnetic resonance (MRIs and MRAs), and nuclear medicine studies, which includes PET scans in a provider's office or freestanding radiology center. **$275.00** copay for each visit for the following Medicare-covered diagnostic radiology services: computed tomography (CT), magnetic resonance (MRIs and MRAs), and nuclear medicine studies, which includes PET scans in the outpatient department of a network hospital or facility. **$50.00** copay for covered ultrasounds in a provider's office or freestanding radiology center. **$110.00** copay for covered ultrasounds in the outpatient department of a network hospital or facility. **$180.00** copay for other covered diagnostic radiology services in

Services that are covered for you	**What you must pay** when you get these services
	a provider's office or freestanding radiology center. **$275.00** copay for other covered diagnostic radiology services in the outpatient department of a network hospital or facility. **$0.00** copay for covered blood, blood storage, processing and handling services. **20%** coinsurance for surgery bandages and supplies, such as casts and splints. **$0.00** copay for hemoglobin A1c or urine tests to check albumin levels. Your provider must get the plan's approval before you get complex imaging or some diagnostic, radiology therapy and lab services. These include radiation therapy, PET, CT, SPECT, MRI scans, heart tests called echocardiograms, lab tests, genetic tests, sleep studies and related supplies. **Out-of-network:** **30%** coinsurance for lab services.

Services that are covered for you	**What you must pay** when you get these services
	30% coinsurance for each diagnostic procedure or test. **30%** coinsurance for tests to confirm COPD. **20%** coinsurance for each covered radiation therapy service. **30%** coinsurance for covered diagnostic radiology services. **30%** coinsurance for covered X-rays. **$0.00** copay for covered blood, blood storage, processing and handling services. **30%** coinsurance for surgical supplies, splints and casts. **30%** coinsurance for Hemoglobin A1c tests or urine tests to check Albumin levels.
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	**In-network:** **$275.00** copay for each observation room service you get at an outpatient hospital. **Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	**30%** coinsurance for each observation room service you get at an outpatient hospital.
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital	**In-network:** **$275.00** copay for each surgical or observation room service you get at an outpatient hospital. **$55.00** copay for each covered partial hospitalization visit for mental health or substance abuse. **20%** coinsurance for medical supplies such as splints and casts. If medical supplies are billed as part of your outpatient hospital

Services that are covered for you	**What you must pay** when you get these services
• Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask! This fact sheet is available on the Web at https://es.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week. Prior authorization may be required.	service, the outpatient hospital cost share will apply. **Out-of-network:** **30%** coinsurance for each surgical or observation room service you get at an outpatient hospital. **30%** coinsurance for each partial hospitalization visit for mental health or substance abuse. **30%** coinsurance for medical supplies such as splints and casts. If medical supplies are billed as part of your outpatient hospital service, the outpatient hospital cost share will apply. **In- and out-of-network:** Your cost share for emergency room visits, outpatient diagnostic tests, outpatient therapeutic services and lab tests are listed under those items elsewhere in this chart. Please see the Medicare Part B drugs section for details on certain drugs and biologicals.

Services that are covered for you	**What you must pay** when you get these services
	Look for the apple icon to learn about certain screenings and preventive care services.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws. Prior authorization may be required.	**In-network:** **$40.00** copay for each covered therapy visit. This applies to individual or group therapy. **Out-of-network:** **30%** coinsurance for each covered therapy visit. This applies to individual or group therapy.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs). Prior authorization may be required.	**In-network:** **$35.00** copay for each covered physical and speech therapy visit. **$35.00** copay for each covered occupational therapy visit. **Out-of-network:** **30%** coinsurance for each covered physical, occupational and speech therapy visit.
Outpatient substance use disorder services Outpatient and ambulatory substance use treatment is supervised by an appropriate licensed professional. Outpatient treatment is provided for individuals or groups, and family therapy may be an additional component. Additional services may be covered in lieu of	**In-network:** **$45.00** copay for each covered therapy visit. This applies to individual or group therapy.

Services that are covered for you	**What you must pay** when you get these services
hospitalization, or as a step-down after hospitalization for substance use-related conditions. Prior authorization may be required.	**Out-of-network:** **30%** coinsurance for each covered therapy visit. This applies to individual or group therapy.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Prior authorization may be required.	**In-network:** **$245.00** copay for each covered surgery in an ambulatory surgical center. **$275.00** copay for each covered surgery or observation room service in an outpatient hospital. **$0.00** copay for a screening exam of the colon that includes a biopsy or removal of any growth or tissue when you get it at an outpatient or ambulatory surgical center. **Out-of-network:** **30%** coinsurance for each covered surgery in an ambulatory surgical center. **30%** coinsurance for each covered surgery or observation room service in an outpatient hospital. **30%** coinsurance for a screening exam of the colon that includes a biopsy or removal of any growth

Services that are covered for you	**What you must pay** when you get these services
	or tissue when you get it at an outpatient or ambulatory surgical center.
Over the Counter (OTC) products This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$75** every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts expire at the end of the calendar year. This spending allowance will be on your Benefits Mastercard® Prepaid Card and can be used to buy health and wellness products like vitamins, first-aid supplies, pain relievers, and more. The Benefits Prepaid Card is automatically loaded with the spending allowance amount each quarter. You can only pay for your own items and cannot convert the card to cash. You have a variety of convenient ways to use your benefit: 1. Shop in-store at participating retailers near you 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 Note: • Purchases are limited to the available benefit dollars. After plan paid OTC benefits, you are responsible for the remaining cost. • Specific name brands may not be available, and quantities may be limited or restricted. • All orders must be placed through the plan's approved vendor,	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. This plan covers certain approved, non-prescription, over-the-counter drugs and health-related items, up to **$75** every quarter. Unused OTC amounts do roll over to the next quarter. Unused OTC amounts expire at the end of the calendar year.

Services that are covered for you	**What you must pay** when you get these services
or your purchase made at a participating retail store. Minimum order quantities and delivery fees may apply for online orders. See ordering site for details. If your Benefits Prepaid Card is not accepted for payment or in the event of a card transaction failure, you may submit a reimbursement request along with proof of payment. Contact information is listed on the back of your Benefits Prepaid Card. A reimbursement request must be submitted within 90 days of the date of payment on your receipt. Please contact Customer Service if you have questions about this benefit.	
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that is more intense than the care received in your doctor's, therapist's licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's office LMFT), or licensed professional counselor's office but less intense than partial hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting. Prior authorization may be required.	**In-network:** **$55.00** copay for each covered partial hospitalization visit. **Out-of-network:** **30%** coinsurance for each covered partial hospitalization visit.
Personal Emergency Response System (PERS) Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the Plan with a	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.

Services that are covered for you	**What you must pay** when you get these services
contracted vendor. The Personal Emergency Response System benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). Please call Customer Service for more information or to request the device.	**$0.00** copay for one personal emergency response system and monthly monitoring by a contracted vendor.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Certain telehealth services including Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with the primary care, individual sessions for mental health visits or individual sessions for psychiatric services. ○ You have the option of getting these services through an in-person visit or by telehealth. If you choose to receive one of these services by telehealth, then you must use a network provider who offers the service by telehealth. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • Telehealth services for monthly end-stage renal disease	**In-network:** **$0.00** copay for each covered Primary Care Provider (PCP) office visit. **$45.00** copay for each covered specialist office visit. **$0.00** copay for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy. **$0.00** copay for each Medicare-covered dental visit for care that is not considered routine. **$45.00** copay for each Medicare-covered hearing exam to diagnose a hearing condition. **$0.00** copay for defined Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with network primary care, a

Services that are covered for you	**What you must pay** when you get these services
related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home • Telehealth services to diagnosis, evaluate or treat of symptoms of an acute stroke, regardless of your location • Telehealth services to members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders, if: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while receiving these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 7 days **and** ○ The check-in doesn't lead to an office visit within 24 hours or soonest available appointment • Evaluation of video and/or images you sent to your doctor	network mental health provider or network psychiatric provider. All other specialties, Medicare-covered telehealth services will apply the applicable cost share found in this benefit chart based on their specialty. For LiveHealth Online services, please go to the Video Doctor Visits benefit later in this benefit chart. **Out-of-network:** **30%** coinsurance for each covered PCP visit. **30%** coinsurance for each covered specialist visit. **30%** coinsurance for each covered service you get at a retail health clinic. This is a clinic inside of a retail pharmacy. **$0.00** copay for each Medicare-covered dental visit for care that is not considered routine. **30%** coinsurance for each Medicare-covered hearing exam to diagnose a hearing condition.

Services that are covered for you	**What you must pay** when you get these services
and interpretation and follow-up by your doctor within 24 hours **if**: ○ You're not a new patient **and** ○ The evaluation isn't related to an office visit in the past 7 days **and** ○ The evaluation doesn't lead to an office visit within 24 hours or soonest available appointment • Consultation your doctor has with other doctors by telephone, internet, or electronic health record • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) Prior authorization may be required.	
Podiatry services - Medicare-covered Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs Prior authorization may be required.	**In-network:** **$45.00** copay for each non-routine Medicare-covered foot care visit. This is for diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). **$0.00** copay for each routine Medicare-covered foot care visit. This is for routine foot care for members with certain

Services that are covered for you	**What you must pay** when you get these services
	medical conditions affecting the lower limbs. **Out-of-network:** **30%** coinsurance for each Medicare-covered foot care visit.
Podiatry services - Supplemental This plan covers additional foot care services not covered by Original Medicare: • Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet • Unlimited routine foot care visits each year. Prior authorization may be required.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for each visit. **Out-of-network:** **30%** coinsurance for each visit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	**In-network:** There is no coinsurance, copayment, or deductible for an annual PSA test. **Out-of-network:** **30%** coinsurance for each prostate cancer screening. **30%** coinsurance for a digital rectal exam.
Prosthetic and orthotic devices and related supplies	**In-network:**

Services that are covered for you	**What you must pay** when you get these services
Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: testing, fitting, or training in the use of prosthetic and orthotic devices as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more detail. Prior authorization may be required.	**20%** coinsurance for covered prosthetic devices and supplies. You must get prosthetic devices and supplies from a medical supply (DME) provider who works with this plan. They will not be covered if you buy them from a pharmacy. If you get a prosthetic or orthotic device while you are getting inpatient services at a hospital or skilled nursing facility, the cost will be included in your inpatient claim. **Out-of-network:** **30%** coinsurance for prosthetic devices and supplies.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease. Prior authorization may be required.	**In-network:** **$15.00** copay for each covered pulmonary rehabilitation visit. **Out-of-network:** **30%** coinsurance for each covered pulmonary rehabilitation visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol but aren't alcohol	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and

Services that are covered for you	**What you must pay** when you get these services
dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	counseling to reduce alcohol misuse preventive benefit. **Out-of-network:** **30%** coinsurance for the screening and counseling to reduce alcohol misuse.
Screening for lung cancer with low dose computed tomography (LDCT) For qualified individuals, a LDCT is covered every 12 months. **Eligible members are:** people aged 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 and who currently smoke or have quit smoking within the last 15 years, who receive an order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must receive an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT. **Out-of-network:** **30%** coinsurance for counseling and shared decision making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit. **Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**30%** coinsurance for each Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, **Medicare Part B prescription drugs.** You pay the inpatient hospital member cost share for dialysis services that you receive while admitted to an inpatient hospital.	**In-network:** **$0.00** copay for each covered kidney disease education service visit. **20%** coinsurance services for: • Kidney dialysis when you use a provider in our plan or you are out of the service area for a short time • Dialysis equipment or supplies • Dialysis home support services **$0.00** copay for each covered training session to learn how to care for yourself if you need dialysis. You don't need the plan's approval before getting dialysis. But please let us know when you need to start this care so we can work with your providers. **Out-of-network:**

Services that are covered for you	**What you must pay** when you get these services
	30% coinsurance for each covered kidney disease education service visit. **20%** coinsurance services for kidney dialysis. **20%** coinsurance for each covered training session to learn how to care for yourself if you need dialysis. **20%** coinsurance for home support services and home dialysis equipment and supplies. You don't need the plan's approval before getting dialysis. But please let us know when you need to start this care so we can work with your providers.
SilverSneakers **SilverSneakers® Membership** SilverSneakers can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers at participating locations[1]. You have access to instructors who lead specially designed group exercise classes[2]. At participating locations nationwide[1], you can take classes[2] plus use exercise equipment and other amenities. Additionally, SilverSneakers FLEX® gives you options to get active outside of traditional gyms (like recreation centers, malls and parks). SilverSneakers also connects you to a support network and virtual resources through SilverSneakers Live classes, SilverSneakers On-Demand™ and our mobile app, SilverSneakers GO™. All you need to get started is your	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for the SilverSneakers® Fitness Program.

Services that are covered for you	**What you must pay** when you get these services
personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (TTY: 711) Monday through Friday, 8 a.m. to 8 p.m. ET. Always talk with your doctor before starting an exercise program. [1]Participating locations ("PL") are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. [2]Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is not a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. SilverSneakers is a registered trademark of Tivity Health, Inc. © 2024 Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, see Chapter 10 of this document. Skilled nursing facilities are sometimes called SNFs.) 100 days per benefit period. No prior hospital stay required. Covered services include but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors)	**In-network:** For covered SNF stays: Days 1 - 20: **$0.00** per day / Days 21 - 100: **$203.00** per day The hospital should tell the plan within one business day of any emergency admission. Your cost share starts the day you are admitted as an inpatient in a hospital or skilled nursing facility. You have no cost share for the day you are discharged. Your skilled nursing care

Services that are covered for you	**What you must pay** when you get these services
• Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse or domestic partner is living at the time you leave the hospital Prior authorization may be required.	benefits are based on the date of admission. If you are admitted in 2025 and are discharged in 2026, the 2025 copays will apply until you have not had any inpatient care in an acute hospital, a SNF, or an inpatient mental health facility for 60 days in a row. **Out-of-network:** For covered SNF stays: **30%** coinsurance per stay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	**What you must pay** when you get these services
cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.	**Out-of-network:** **30%** coinsurance for each smoking and tobacco use cessation.
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD). Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider. Prior authorization may be required.	**In-network:** **$20.00** copay for each covered SET session. **Out-of-network:** **30%** coinsurance for each covered SET session.
Urgently needed services A plan-covered service requiring immediate medical attention that is	**$25.00** copay for each covered urgently needed service.

Services that are covered for you	**What you must pay** when you get these services
not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or even if you are inside the service area of the plan, it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contracts. Your plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable. Urgently needed service coverage is worldwide.	This plan covers worldwide urgent care services if you're traveling outside of the United States for less than six months. Coverage is limited to **$100,000** per year for worldwide urgent care and 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. **$90.00** copay for each covered worldwide urgently needed service. If you need urgent care outside the United States or its territories, please call the Blue Cross Blue Shield Global Core program at 1-800-810-BLUE (1-800-810-2583). Or call collect at 1-804-673-1177. We can help you 24 hours a day, 7 days a week, 365 days a year.
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed	Any costs you pay for Medicare Non-covered Services will not

Services that are covered for you	**What you must pay** when you get these services
therapists, psychologists and psychiatrists through live, two-way video on your smartphone, tablet or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health 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 talk with a therapist[2] or make an appointment and talk with a psychiatrist[3] from the privacy of your home. Video doctor visits are intended to complement face-to-face visits with a board-certified physician and are available for most types of care. LiveHealth Online is offered through an arrangement with Amwell, a separate company, providing telehealth services on behalf of your health plan. [1]Prescription is prescribed based on physician recommendations and	count toward your maximum out-of-pocket amount. **$0.00** copay for video doctor visits using LiveHealth Online.

Services that are covered for you	**What you must pay** when you get these services
state regulations (rules). [2]Appointments are typically scheduled within seven days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. [3]Appointments are typically scheduled within 28 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	
Vision care - Medicare-covered Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts • For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 65 or older • For people with diabetes, screening for diabetic retinopathy is covered once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)	**In-network:** For in-network Medicare-covered vision care, you must use a provider in the Anthem Veteran (PPO) specialty medical network. You can find them in the Provider Directory. To learn more, call the Customer Service number on the back cover of this document. **$45.00** copay for each Medicare-covered exam to treat an eye condition. **$0.00** copay for the glaucoma screening for people who are at high risk of glaucoma. After you have cataract surgery, **$0.00** copay for one pair of Medicare-covered eyeglasses or contact lenses. Eye exams and early detection are important as some problems

Services that are covered for you	**What you must pay** when you get these services
	do not have symptoms. It matters to find problems early. Your doctor will tell you what tests you need. Talk to your doctor to see if you qualify. **$0.00** copay for Medicare-covered diabetic retinopathy. Your medical vision benefit does not include a routine eye exam (refraction) for the purpose of prescribing glasses. If you have coverage under a supplemental benefit you will see that information in the section below. **Out-of-network:** **30%** coinsurance for each Medicare-covered exam to treat an eye condition. **30%** coinsurance for the glaucoma screening for people who are at high risk of glaucoma. **$0.00** copay for one pair of Medicare-covered eye glasses or contact lenses after cataract surgery.
Vision care - Supplemental The plan provides additional vision coverage not covered by Original	Any costs you pay for Medicare Non-covered Services will not count toward your maximum

Services that are covered for you	**What you must pay** when you get these services
Medicare. This plan covers 1 routine eye exam(s) every year. **$69** maximum eye exam coverage amount. This plan covers up to **$200** for eyeglasses or contact lenses every year.	out-of-pocket amount. You may have to pay more if you use an out-of-network provider. Please see Optional Supplemental Benefits in Chapter 4 Section 2.2 for more options. **In- and out-of-network:** **$0.00** copay for one routine eye exam every calendar year. This plan covers up to **$69.00** for an eye exam each year. Refractions are covered as part of a routine eye exam and are not covered if billed separately. **$0.00** copay for eyewear each year up to the allowance amount. The amount the plan covers for eyewear is deducted from the total charged amount billed to insurance. After plan paid benefits for eyewear are applied, you are responsible for any remaining costs, including non-covered services. Benefits available under this plan cannot be combined with

Services that are covered for you	**What you must pay** when you get these services
	any other in-store discounts. If you use an out-of-network provider, you may be required to pay in full at the time of service and submit a request for reimbursement. To submit a request form for reimbursement, you will need to provide proof of payment and an itemized receipt. For more information, call the Customer Service number on the back cover of this document.
Visitor/Traveler The visitor/traveler program provides access to in-network level of benefits for plan covered services when you are traveling outside our service area for up to 12 months. Network and Service Area restrictions apply.	See Section 2.3 of this chapter for more detail.
Welcome to Medicare preventive visit The plan covers the one-time *Welcome to Medicare* preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots, (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your *Welcome to Medicare* preventive visit.	**In-network:** There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit. **Out-of-network:** **30%** coinsurance for the *Welcome to Medicare* preventive visit.

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

The Medicare allowable amount for covered services.

or

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

Dental services – supplemental limitations and exclusions

Our plan partners with Liberty Dental to provide your dental benefits. Please note, implant and crown services require clinical review for prior authorization before treatment. Requests for these services are clinically reviewed to determine if they are appropriate and meet industry standards, clinical criteria and guidelines for coverage. Treatment requests which are not medically necessary or do not meet clinical criteria and guidelines will not be covered. If prior authorization is denied, the service will not be covered, and you will be responsible for all associated costs.

To locate a network provider or for questions related to Liberty Dental Plan's clinical guidelines you may call Liberty Dental Member Services at 1-888-700-0992 or search the Liberty Dental website at https://client.libertydentalplan.com/healthyblue. It is recommended you work with your in-network dentist to check benefit coverage prior to obtaining dental services. Services performed by an out-of-network provider are only covered if listed in the Dental services – Supplemental section of the Chapter 4 Medical Benefits Chart.

Coverage is limited to the services listed in the Dental services – Supplemental section of the Chapter 4 Medical Benefits Chart with the following additional limitations and exclusions:

Crown Services

1. Requests for crowns require the tooth/teeth to have a good long-term restorative, endodontic, and periodontal (at least 50% bone support) prognosis for approval.
2. Requests for crowns on teeth without root canal treatment must show evidence of decay, fracture, failing restoration, etc., undermining more than 50% of the tooth to be considered for coverage.
3. Requests for crowns require the corresponding tooth in the opposite arch (upper or lower depending on crown being requested) to be present.
4. The replacement of existing crowns are not covered if they are deemed satisfactory or can be fixed to a satisfactory condition, upon clinical review.
5. Cosmetic or experimental dental services, and/or procedures not generally performed in a general dentist office.

a. Crowns for the purposes of esthetics, or as a result of normal wear & attrition, recession, abfraction and/or abrasion are not covered.

Implant Services

1. Implant services are only covered by the Plan under certain circumstances in accordance with Liberty's clinical criteria. A member's overall oral condition will be evaluated when determining appropriateness for implant coverage. Implants used to replace a back tooth would only be covered when there are enough teeth remaining and a full or partial denture is not more appropriate.

   a. Implant placement for a back tooth must oppose a natural tooth or other fixed dentition for coverage. Fixed dentition is defined as a natural tooth, implant, crown or bridge.

   b. Implant placement for a back tooth is only covered when a functional bite exists between fixed dentition. A functional bite is defined as at least 4 upper back teeth occluding against 4 lower back teeth.

   c. Implant placement for a front tooth will only be covered when its placement results in no remaining missing front teeth in that arch.

   d. Prior authorization requests for bone grafting at the time of implant placement that lack radiographic evidence or other sufficient images to support the need for this service will be denied.

   e. Not covered in the presence of moderate-severe periodontal disease or pathology.

   f. Implants placed to retain and support dentures are covered when considered necessary due to inadequate existing retention. In full denture cases, up to four implants will be covered on the upper arch and two covered on the lower arch unless documentation supports the need for additional implants.

Other Limitations and Exclusions

- Services requested without sufficient documentation to adequately review the services for necessity, as defined by Liberty's Clinical Criteria and Guidelines, will be denied.
- It is the responsibility of the provider to submit all necessary documentation to support that the requested service meets plan criteria and is medically necessary. This documentation may include the submission of full mouth X-rays and your comprehensive treatment plan. Missing required documentation will result in the requested service being denied.
- Any procedure not specifically listed as a covered benefit in Dental services – Supplemental section of the Chapter 4 Medical Benefits Chart, is not covered.
- Any requested services that are performed in conjunction with or reliant upon the completion of a denied service will also be denied.

- Any treatment covered under an individual or group medical plan, auto insurance, no fault auto insurance or uninsured motorist policy, to the extent permitted by federal or state statute, is not covered.
- Treatment as a result of civil insurrection, duty as a member of the armed forces of any state or country, engaging in an act of declared or undeclared war, intentional or unintentional nuclear explosion or other release of nuclear energy, whether in peacetime or wartime, is not covered.
- Services for injuries and/or conditions which are paid or payable under Worker's Compensation or Employer Liability Laws, and treatment provided without cost to you by any municipality, county, or other political subdivision is not covered.
- Fees related to broken appointments, preparing or copying dental reports, duplication of x rays, itemized bills or claim forms are not covered.

Section 2.2 Extra optional supplemental benefits you can buy

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

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

You can pay your optional supplemental benefits monthly plan premium combined with your regular monthly plan premium or late-enrollment penalty, if you have one. The premium information provided in Chapter 1:, Section 4 also applies to your optional supplemental benefits monthly premium, with one exception. As Chapter 1:, Section 4 indicates, if you are enrolled in optional supplemental benefits and do not pay your premium within 60 days, you will be downgraded to the base plan and the optional supplemental benefits will be removed from your plan.

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

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

disenrolled from these benefits, you will not be able to re-enroll until the next Annual Enrollment Period.

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

Optional supplemental benefits	What you must pay when you get these services
Optional supplemental package 1 – Preventive dental package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 1 – Preventive Dental Package.	
Premium	$17.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): • D0120 – Periodic oral evaluation – established patient • D0140 – Limited oral evaluation – problem focused • D0150 – Comprehensive oral evaluation – new or established patient • D0160 – Extensive oral exam problem focused • D0170 – Re-evaluation-limited problem focused • D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. • D0210 – Intraoral – complete series (including bitewings) • D0220 – Intraoral – periapical first radiographic image • D0230 – Intraoral – periapical each additional	**In- and out-of-network:** The plan will pay up to $500 for preventive dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. To receive in-network benefits, you must use a LIBERTY Dental provider. **In-network:** **You pay no copay** of the covered charges for preventive dental services listed when using an in-network provider. **Out-of-network:** **You pay 20%** of the covered charges as your portion for the preventive dental services when using an out-of-network provider.

Optional supplemental benefits	What you must pay when you get these services
radiographic image • D0270 – Bitewings – single film • D0272 – Bitewings – two films • D0274 – Bitewings – four films • D0277 – Vertical bitewings – 7 to 8 radiographic images • D0330 – Panoramic film Two cleanings per year • D1110 – Prophylaxis – adult Two fluoride treatments per year • D1208 – Topical application of fluoride	**Exclusions & Limitations:** • You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. • Restorative dental (fillings and crowns), endodontic, periodontic, prosthodontic, and oral surgeries are excluded. • Contracted providers will bill the plan directly for covered services. However, out-of-network providers may require you to submit the claims directly to the contracted vendor. • Out-of-network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. • Not all of the plan's medical providers are affiliated with LIBERTY Dental. • Your costs for these services will not count toward your maximum out-of-pocket amount.

Optional supplemental benefits	What you must pay when you get these services
Optional supplemental package 2 – Dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 2 – Dental and Vision Package.	
Premium	$26.00 monthly premium
Dental services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): • D0120 – Periodic oral evaluation – established patient • D0140 – Limited oral evaluation – problem focused • D0150 – Comprehensive oral evaluation – new or established patient • D0160 – Extensive oral exam problem focused • D0170 – Re-evaluation-limited problem focused • D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and** one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. • D0210 – Intraoral – complete series (including bitewings) • D0220 – Intraoral – periapical first radiographic image • D0230 – Intraoral – periapical each additional radiographic image • D0270 – Bitewings – single film • D0272 – Bitewings – two films • D0274 – Bitewings – four films	**In- and out-of-network:** The plan will pay up to $1,000 for dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. To receive in-network benefits, you must use a LIBERTY Dental provider. **Preventive dental services** **In-network:** **You pay no copay** of the covered charges for preventive dental services listed when using an in-network provider. **Out-of-network:** **You pay 30%** of the covered charges as your portion for the preventive dental services when using an out-of-network provider. **Restorative dental services (fillings)** **In-network:** **You pay 20%** of the covered charges as your portion for restorative dental

Optional supplemental benefits	What you must pay when you get these services
• D0277 – Vertical bitewings – 7 to 8 radiographic images • D0330 – Panoramic film Two cleanings per year • D1110 – Prophylaxis – adult Two fluoride treatments per year • D1208 – Topical application of fluoride **Restorative dental services (fillings)** include the following procedures: • D2140 – Amalgam – one surface, primary or permanent • D2150 – Amalgam – two surfaces, primary or permanent • D2160 – Amalgam – three surfaces, primary or permanent • D2161 – Amalgam – four or more surfaces, primary or permanent • D2330 – Resin-based composite – one surface, anterior • D2331 – Resin-based composite – two surfaces, anterior • D2332 – Resin-based composite – three surfaces, anterior • D2335 – Resin-based composite – four or more surfaces or involving incisal angle (anterior) • D2391 – Resin-based composite – one surface, posterior • D2392 – Resin-based composite – two surfaces, posterior • D2393 – Resin-based composite – three surfaces, posterior • D2394 – Resin-based composite – four or more surfaces, posterior **Endodontic, periodontic and oral surgery services** include the following procedures: • D3110 – Pulp cap – direct (excluding final restoration)	services listed when using an in-network provider. **Out-of-network:** **You pay 60%** of the covered charges as your portion for the restorative dental services listed when using an out-of-network provider. **Endodontic, periodontic and oral surgery services** Endodontic, periodontic and oral surgery dental services include, but are not limited to, the following: • Root canal treatment • Periodontal scaling and root planing • Simple and surgical extractions (limited to once per tooth per lifetime) **In-network:** **You pay 50%** of the covered charges as your portion for endodontic, periodontic, and oral surgery services listed when using an in-network provider. **Out-of-network:** **You pay 75%** of the covered charges as your portion for the endodontic, periodontic, and oral surgery services listed when using an out-of-network provider. **Exclusions & limitations:** • You must pay any extra costs or services outside of the

Optional supplemental benefits	What you must pay when you get these services
• D3120 – Pulp cap – indirect (excluding final restoration) • D3220 – Therapeutic pulpotomy (excluding final restoration)– removal of pulp coronal to the dentinocemental junction & application of medicament • D3221 – Pulpal debridement, primary & permanent teeth • D3310 – Root canal – anterior (excluding final restoration) • D3320 – Root canal – bicuspid (excluding final restoration) • D3330 – Root canal – molar (excluding final restoration) • D3346 – Retreatment of previous root canal therapy –anterior • D3347 – Retreatment of previous root canal therapy –bicuspid • D3348 – Retreatment of previous root canal therapy – molar • D3351 – Apexification/recalcification – initial visit (apical closure/ calcific repair of perforations, root resorption, etc.) • D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) • D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.) • D3410 – Apicoectomy/periradicular surgery – anterior • D3421 – Apicoectomy/periradicular surgery – bicuspid (first root) • D3425 – Apicoectomy/periradicular surgery – molar (first root) • D3430 – Retrograde filling – per root	dental codes and coverage outlined in this section directly to the provider. • Dentures and crowns are not covered under this package. • Contracted providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims directly to the contracted vendor. • Out-of-Network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. • Not all of the plan's medical providers are affiliated with LIBERTY Dental. • Your costs for these services will not count toward your maximum out-of-pocket amount.

Optional supplemental benefits	What you must pay when you get these services
• D3450 – Root amputation – per root • D3920 – Hemisection (including any root removal), not including root canal therapy • D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant • D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant • D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant • D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant • D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant • D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant • D4270 – Pedicle soft tissue graft procedure • D4341 – Periodontal scaling & root planing – four or more teeth per quadrant • D4342 – Periodontal scaling & root planing – one to three teeth per quadrant • D4355 – Full mouth debridement to enable comprehensive evaluation & diagnosis • D4910 – Periodontal maintenance • D7111 – Extraction, coronal remnants – deciduous tooth • D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) • D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap & removal of bone	

Optional supplemental benefits	What you must pay when you get these services
and/or section of tooth • D7220 – Removal of impacted tooth – soft tissue • D7230 – Removal of impacted tooth – partially bony • D7240 – Removal of impacted tooth – completely bony • D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications • D7250 – Surgical removal of residual tooth roots (cutting procedure) • D9222 – Deep sedation/general anesthesia - first 15 minutes • D9223 – Deep sedation/general anesthesia - each subsequent 15 minutes • D9230 – Analgesia, anxiolysis, inhalation of nitrous oxide • D9239 – Intravenous moderation (conscious) • D9243 – Intravenous moderate (conscious) sedation/analgesia - each subsequent 15 minute increment • D9248 – Non intravenous conscious sedation • D9310 – Consultation diagnostic service provided by dentist or physician other than requesting dentist or physician	
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: • A routine eye exam is covered under your medical benefits once per calendar year. • Post cataract surgery and associated eyewear is covered under your medical benefits.	**In- and out-of-network** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. In-network coverage for eyewear benefits are vision services available only through Blue View Vision Insight network providers. Benefits available under this plan cannot be

Optional supplemental benefits	What you must pay when you get these services
	combined with any other in-store discounts. $150 reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating or nonparticipating provider. After the plan-paid benefits, the member is responsible for the remaining cost. **Exclusions & Limitations:** • You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. • Safety eyewear, non-prescription sunglasses, glass lenses, non-prescription lenses or contacts, or lens treatments are not covered. • Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider directly for availability. • Contracted providers will bill directly for covered services. However, out-of-network

Optional supplemental benefits	What you must pay when you get these services
	providers may require you to submit the claims directly to the contracted vendor. • Not all of the plan's medical providers are affiliated with Blue View Vision Insight. • Your costs for these services will not count toward your maximum out-of-pocket amount.
Optional supplemental package 3 – Enhanced dental and vision package As a Supplemental Benefit, these services are not routinely covered under Original Medicare. They are offered for an additional premium through this Optional Supplemental Package 3 – Enhanced Dental and Vision Package.	
Premium	$55.00 monthly premium
Dental Services **Preventive dental services** include the following procedures, limitations and codes listed below: Two oral exams each year (from the following codes): • D0120 – Periodic oral evaluation – established patient • D0140 – Limited oral evaluation – problem focused • D0150 – Comprehensive oral evaluation – new or established patient • D0160 – Extensive oral exam problem focused • D0170 – Re-evaluation-limited problem focused • D0180 – Comprehensive periodontal evaluation – new or established patient Dental X-rays include one full-mouth **or** panoramic X-ray **and**	**In- and out-of-network:** The plan will pay up to $2,000 for dental benefits each year (benefit maximum). Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. To receive in-network benefits, you must use a LIBERTY Dental provider. **Preventive dental services** **In-network:** **You pay no copay** of the covered charges for preventive dental services

Optional supplemental benefits	What you must pay when you get these services
one set/series of bitewing X-rays each year **and** up to seven periapical images per calendar year. • D0210 – Intraoral – complete series (including bitewings) • D0220 – Intraoral – periapical first radiographic image • D0230 – Intraoral – periapical each additional radiographic image • D0270 – Bitewings – single film • D0272 – Bitewings – two films • D0274 – Bitewings – four films • D0277 – Vertical bitewings – 7 to 8 radiographic images • D0330 – Panoramic film Two cleanings per year • D1110 – Prophylaxis – adult Two fluoride treatments per year • D1208 – Topical application of fluoride **Restorative dental (fillings) services** include the following procedures: • D2140 – Amalgam – one surface, primary or permanent • D2150 – Amalgam – two surfaces, primary or permanent • D2160 – Amalgam – three surfaces, primary or permanent • D2161 – Amalgam – four or more surfaces, primary or permanent • D2330 – Resin - based composite – one surface, anterior • D2331 – Resin - based composite – two surfaces, anterior • D2332 – Resin - based composite – three surfaces, anterior • D2335 – Resin - based composite – four or more	listed when using an in-network provider. **Out-of-network:** **You pay 30%** of the covered charges as your portion for the preventive dental services when using an out-of-network provider. **Restorative dental services (fillings)** **In-network:** **You pay 20%** of the covered charges as your portion for restorative dental services listed when using an in-network provider. **Out-of-network:** **You pay 60%** of the covered charges as your portion for the restorative dental services listed when using an out-of-network provider. **Endodontic, periodontic, prosthodontic and oral surgery services** Endodontic, periodontic, prosthodontic and oral surgery dental services include, but are not limited to, the following: • Root canal treatment • Periodontal scaling and root planing • Simple and surgical extractions (limited to once per tooth per lifetime) • Crowns (once per tooth every

Optional supplemental benefits	What you must pay when you get these services
surfaces or involving incisal angle (anterior) • D2391 – Resin - based composite – one surface, posterior • D2392 – Resin - based composite – two surfaces, posterior • D2393 – Resin - based composite – three surfaces, posterior • D2394 – Resin - based composite – four or more surfaces, posterior **Enhanced restorative (crown services), endodontics (root canal services), periodontics, prosthodontics (denture services), oral surgery, and anesthesia services** include the following procedures: • D2740 – Crown – porcelain/ceramic substrate • D2750 – Crown – porcelain fused to high noble metal • D2751 – Crown – porcelain fused to predominantly base metal • D2752 – Crown – porcelain fused to noble metal • D2753 – Crown – porcelain fused to titanium and titanium alloys • D2790 – Crown – full cast high noble metal • D2791 – Crown – full cast predominantly base metal • D2792 – Crown – full cast noble metal • D2910 – Recement inlay, onlay, or partial coverage restoration • D2915 – Recement cast or prefabricated post & core • D2920 – Recement crown • D2940 – Sedative filling • D2950 – Core buildup, including any pins • D2951 – Pin retention – per tooth, in addition to	five years) • Complete denture, immediate denture, or partial denture (one set of dentures every five years) • Denture adjustment, repair, replacement rebasing and relining • Local anesthesia (a drug to numb a part of the body) or regional block anesthesia **In-network:** **You pay 50%** of the covered charges as your portion for enhanced restorative, endodontic, periodontic, prosthodontic and oral surgery services listed when using an in-network provider. **Out-of-network:** **You pay 75%** of the covered charges as your portion for enhanced restorative, endodontic, periodontic, prosthodontic and oral surgery services listed when using an out-of-network provider. **Exclusions & limitations:** • You must pay any extra costs or services outside of the dental codes and coverage outlined in this section directly to the provider. • Contracted providers will bill directly for covered services.

Optional supplemental benefits	What you must pay when you get these services
restoration • D2952 – Post & core in addition to crown, indirectly fabricated • D2954 – Prefabricated post & core in addition to crown • D2955 – Post removal (not in conjunction with endodontic therapy) • D3110 – Pulp cap – direct (excluding final restoration) • D3120 – Pulp cap – indirect (excluding final restoration) • D3220 – Therapeutic pulpotomy (excluding final restoration) – removal of pulp coronal to the dentinocemental junction & application of medicament • D3221 – Pulpal debridement, primary & permanent teeth • D3310 – Root canal – anterior (excluding final restoration) • D3320 – Root canal – bicuspid (excluding final restoration) • D3330 – Root canal – molar (excluding final restoration) • D3346 – Retreatment of previous root canal therapy – anterior • D3347 – Retreatment of previous root canal therapy – bicuspid • D3348 – Retreatment of previous root canal therapy – molar • D3351 – Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.) • D3352 – Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.) • D3353 – Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption,	However, out-of-network providers may require you to submit the claims directly to the contracted vendor. • Out-of-Network services are reimbursed at usual and customary charges, which are not always billed charges by the provider. • Not all of the plan's medical providers are affiliated with LIBERTY Dental. • Your costs for these services will not count toward your maximum out-of-pocket amount. Crown services require clinical review for prior authorization before treatment. Requests for these services are clinically reviewed to determine if they are appropriate and meet industry standards, clinical criteria and guidelines for coverage. Treatment requests which are not medically necessary or do not meet clinical criteria and guidelines will not be covered. If prior authorization is denied, the service will not be covered, and you will be responsible for all associated costs. • Requests for crowns require the tooth/teeth to have a good long-term restorative, endodontic, and periodontal (at least 50% bone support)

Optional supplemental benefits	What you must pay when you get these services
etc.) • D3410 – Apicoectomy/periradicular surgery – anterior • D3421 – Apicoectomy/periradicular surgery – bicuspid (first root) • D3425 – Apicoectomy/periradicular surgery – molar (first root) • D3430 – Retrograde filling – per root • D3450 – Root amputation – per root • D3920 – Hemisection (including any root removal), not including root canal therapy • D4210 – Gingivectomy or gingivoplasty – four or more contiguous teeth or bounded teeth spaces per quadrant • D4211 – Gingivectomy or gingivoplasty – one to three contiguous teeth or bounded teeth spaces per quadrant • D4240 – Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces per quadrant • D4241 – Gingival flap procedure, including root planing – one to three contiguous teeth or bounded teeth spaces per quadrant • D4260 – Osseous surgery (including flap entry & closure) – four or more contiguous teeth or bounded teeth spaces per quadrant • D4261 – Osseous surgery (including flap entry & closure) – one to three contiguous teeth or bounded teeth spaces per quadrant • D4270 – Pedicle soft tissue graft procedure • D4341 – Periodontal scaling & root planing – four or more teeth per quadrant • D4342 – Periodontal scaling & root planing – one to three teeth per quadrant • D4355 – Full mouth debridement to enable	prognosis for approval. • Requests for crowns on teeth without root canal treatment must show evidence of decay, fracture, failing restoration, etc., undermining more than 50% of the tooth to be considered for coverage. • Requests for crowns require the corresponding tooth in the opposite arch (upper or lower depending on crown being requested) to be present. • The replacement of existing crowns are not covered if they are deemed satisfactory or can be fixed to a satisfactory condition, upon clinical review. • Cosmetic or experimental dental services, and/or procedures not generally performed in a general dentist office. ○ Crowns for the purposes of esthetics, or as a result of normal wear & attrition, recession, abfraction and/or abrasion are not covered. Services requested without sufficient documentation to adequately review the services for necessity, as defined by LIBERTY Dental Clinical Criteria

Optional supplemental benefits	What you must pay when you get these services
comprehensive evaluation & diagnosis • D4910 – Periodontal maintenance • D5110 – Complete denture – maxillary • D5120 – Complete denture – mandibular • D5130 – Immediate denture – maxillary • D5140 – Immediate denture – mandibular • D5211 – Maxillary partial denture – resin base (including any conventional clasps, rests & teeth) • D5212 – Mandibular partial denture – resin base (including any conventional clasps, rests & teeth) • D5213 – Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth) • D5214 – Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests & teeth) • D5421 – Adjust partial denture – maxillary • D5422 – Adjust partial denture – mandibular • D5511 – Repair broken complete denture base, mandibular • D5512 – Repair broken complete denture base, maxillary • D5520 – Replace missing or broken teeth – complete denture (each tooth) • D5611 – Repair resin denture base, mandibular • D5612 – Repair resin denture base, maxillary • D5621 – Repair cast framework, mandibular • D5622 – Repair cast framework, maxillary • D5630 – Repair or replace broken clasp • D5640 – Replace broken teeth – per tooth • D5650 – Add tooth to existing partial denture	and Guidelines, will be denied.

Optional supplemental benefits	What you must pay when you get these services
• D5660 – Add clasp to existing partial denture • D5670 – Replace all teeth & acrylic on cast metal framework (maxillary) • D5671 – Replace all teeth & acrylic on cast metal framework (mandibular) • D5710 – Rebase complete maxillary denture • D5711 – Rebase complete mandibular denture • D5720 – Rebase maxillary partial denture • D5721 – Rebase mandibular partial denture • D5725 – Rebase of hybrid prosthesis • D5730 – Reline complete maxillary denture (chairside) • D5731 – Reline complete mandibular denture (chairside) • D5740 – Reline maxillary partial denture (chairside) • D5741 – Reline mandibular partial denture (chairside) • D5750 – Reline complete maxillary denture (laboratory) • D5751 – Reline complete mandibular denture (laboratory) • D5760 – Reline maxillary partial denture (laboratory) • D5761 – Reline mandibular partial denture (laboratory) • D5765 – Soft liner for complete or partial dentures • D5850 – Tissue conditioning, maxillary • D5851 – Tissue conditioning, mandibular • D5876 – Add metal substructure to acrylic full denture • D7111 – Extraction, coronal remnants – deciduous tooth • D7140 – Extraction, erupted tooth or exposed root (elevation and/or forceps removal) • D7210 – Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth	

Optional supplemental benefits	What you must pay when you get these services
• D7220 – Removal of impacted tooth – soft tissue • D7230 – Removal of impacted tooth – partially bony • D7240 – Removal of impacted tooth – completely bony • D7241 – Removal of impacted tooth – completely bony, with unusual surgical complications • D7250 – Surgical removal of residual tooth roots (cutting procedure) • D7260 – Oroantral fistula closure • D7261 – Primary closure of a sinus perforation • D7280 – Surgical access of an unerupted tooth • D7282 – Mobilization of erupted or malpositioned tooth to aid eruption • D7283 – Placement of device to facilitate eruption of impacted tooth • D7285 – Biopsy of oral tissue – hard (bone, tooth) • D7286 – Biopsy of oral tissue – soft • D7287 – Exfoliative cytological sample collection • D7288 – Brush biopsy – transepithelial sample collection • D7310 – Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant • D7311 – Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant • D7320 – Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant • D7321 – Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces per quadrant • D7410 – Excision of benign lesion of up to 1.25 Cm • D7411 – Excision of benign lesion greater than 1.25 Cm	

Optional supplemental benefits	What you must pay when you get these services
• D7412 – Excision of benign lesion, complicated • D7450 – Removal of benign odontogenic cyst or tumor – lesion diameter up to 1.25 Cm • D7451 – Removal of benign odontogenic cyst or tumor – lesion diameter greater than 1.25 Cm • D7460 – Removal of benign nonodontogenic cyst or tumor – lesion diameter up to 1.25 Cm • D7461 – Removal of benign nonodontogenic cyst or tumor – lesion diameter greater than 1.25 Cm • D7465 – Destruction of lesion(s) by physical or chemical method, by report • D7510 – Incision and drainage of abscess – intraoral soft tissue • D7511 – Incision and drainage of abscess – intraoral soft tissue –complicated (includes drainage of multiple fascial spaces) • D7520 – Incision and drainage of abscess – extraoral soft tissue • D7521 – Incision and drainage of abscess – extraoral soft tissue – complicated (includes drainage of multiple fascial spaces) • D7530 – Removal of foreign body from mucosa, skin or subcutaneous alveolar tissue • D7540 – Removal of reaction-producing foreign bodies, muscoskeletal system • D7961 – Buccal/labial frenectomy (frenulectomy) • D7962 – lingual frenectomy (frenulectomy) • D7963 – Frenuloplasty • D9110 – Palliative treatment • D9120 – Fixed partial denture sectioning • D9210 – Local anesthesia not in conjunction with	

Optional supplemental benefits	What you must pay when you get these services
operative or surgical procedure • D9211 – Regional block anesthesia • D9212 – Trigeminal division block anesthesia • D9215 – Local anesthesia • D9222 – Deep sedation/general anesthesia – first 15 minutes • D9223 – Deep sedation/general anesthesia – each subsequent 15 minutes • D9230 – Analgesia, anxiolysis, inhalation of nitrous oxide • D9239 – Intravenous moderation (conscious) • D9243 – Intravenous moderation (conscious) sedation/ analgesia - each subsequent 15 minute increment • D9248 – Nonintravenous conscious sedation • D9310 – Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	
Vision services Please see the Medical Benefits Chart for more information for these covered medical services, limitations and requirements: • A routine eye exam is covered under your medical benefits once per calendar year. • Post cataract surgery and associated eyewear is covered under your medical benefits.	**In- and out-of-network:** Talk to your provider and confirm all coverage, costs and codes prior to services being rendered. In-network coverage for eyewear benefits are vision services available only through Blue View Vision Insight network providers. Benefits available under this plan cannot be combined with any other in-store discounts. If you use an out of network provider, you will be required to pay in full at the time of service and

Optional supplemental benefits	What you must pay when you get these services
	submit a request for reimbursement. To submit a form for reimbursement, you will need to provide proof of payment and itemized receipt. For more information, call the customer service number on the back cover of this document. $200 reimbursement allowance toward the purchase of eyewear. The benefit applies to corrective (prescription) glasses, lenses, frames and/or contact lenses purchased from a participating or nonparticipating provider. After the plan-paid benefits, the member is responsible for the remaining cost. **Exclusions & Limitations:** • You must pay any extra costs or services outside of the coverage outlined in this section or for any upgrades directly to the provider. • Safety eyewear, nonprescription sunglasses, glass lenses, nonprescription lenses or contacts, or lens treatments are not covered. • Covered benefits cannot be combined with any other in-store discounts. However, some providers have discounts on items/services that are not covered under this benefit. Contact the provider

Optional supplemental benefits	What you must pay when you get these services
	directly for availability. • Contracted providers will bill directly for covered services. However, out-of-network providers may require you to submit the claims directly to the contracted vendor. • Not all of the plan's medical providers are affiliated with Blue View Vision Insight. • Your costs for these services will not count toward your maximum out-of-pocket amount.

Section 2.3 Getting care using our plan's optional visitor/traveler benefit

If you do not permanently move, but you are continuously away from our plan's service area for more than six months, we usually must disenroll you from our plan. However, we offer a visitor/traveler program, which will allow you to remain enrolled when you are outside of our service area for less than 12 months. Under our visitor/traveler program you may receive all plan covered services at in-network cost sharing. Please contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

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

The visitor/travel program will include Blue Medicare Advantage PPO network coverage of all Part A, Part B, and Supplemental benefits offered by your plan outside your service area in 48 states and 2 territories: Alabama, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, Wisconsin and West Virginia. For some of the states listed, MA PPO networks are only available in portions of the state.

In addition, members may:

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

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

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

This section tells you what services are *excluded* from Medicare coverage and therefore, are not covered by this plan.

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered, and our plan will not pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards	**Not covered under any condition.**	
Experimental medical and surgical procedures, equipment and medications. Experimental		• May be covered by Original Medicare under a Medicare-approved clinical

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.		research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		• Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	**Not covered under any condition.**	
Full-time nursing care in your home.	**Not covered under any condition.**	
Custodial care Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition.**	
Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.	**Not covered under any condition.**	
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition.**	
Cosmetic surgery or procedures		• Covered in cases of an accidental injury or for improvement of the functioning

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings or dentures.		• Medicare doesn't cover most dental care, dental procedures, or supplies, like cleanings, fillings, tooth extractions, dentures, dental plates, or other dental devices. This plan covers routine dental care as specified in the Chapter 4 Benefit Chart as a supplemental benefit or purchased as part of an optional supplemental benefit package. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. To utilize this benefit you must use a provider who participates in our routine dental Vendor network. Please contact Customer Service to locate a provider that is within that dental vendors network.
Non-routine dental care		• Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Dental services are excluded

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		from coverage in connection with the care, treatment, filling, removal, or replacement of teeth, or structures directly supporting the teeth, except for inpatient or outpatient hospital services required because of a medical condition. Additionally, some dental services are covered if an integral part of a covered medical procedure. Medicare has specific guidelines for covered services. Contact Customer Service for more information on these limited services.
Routine chiropractic care		• Manual manipulation of the spine to correct a subluxation is covered.
Routine foot care		• Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Medicare covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, heel spurs), but generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, flat foot, or hygienic or other preventive

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		maintenance, including cleaning and soaking the feet). This plan covers additional routine foot care as specified in the Chapter 4 Benefit Chart as a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine podiatry provider network or your services will be considered out of network, even if rendered by a medical provider if they are not part of the Vendors network. Contact Customer Service for more information on these limited services.
Home-delivered meals		• Medicare does not cover home-delivered meals. This plan covers home-delivered meals as specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan.
Orthopedic shoes or supportive devices for the feet		• Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes are for people with diabetic foot disease.
Routine hearing exams, hearing		• Medicare doesn't cover routine

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
aids, or exams to fit hearing aids.		hearing exams, hearing aids, or exams for fitting hearing aids. This plan covers routine hearing care as specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. To utilize this benefit you must use a provider who participates in our routine hearing vendor network. Please contact Customer Service to locate a provider that is within that hearing vendors network or your services will be considered out of network, even if rendered by a medical provider if they are not part of the vendors network.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		• Medicare doesn't cover routine eye exams, eyeglasses or contact lenses. However, an eye exam and one pair of eyeglasses (or contact lenses) are covered by Medicare for people after cataract surgery, that implants an intraocular lens. Medicare coverage of post cataract eyeglasses is limited to standard lenses and standard frames only. Scratch resistant coating, mirror coating, polarization, deluxe lens feature, progressive lenses,

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		polycarbonate (or similar material), high index glass or plastic (light weight or thinness), specialty occupational multifocal lenses, tinted lenses, including photochromatic lenses used as sunglasses, eyeglass cases and deluxe frames are not covered by Medicare. If these items are purchased, you will be responsible for the cost. Anti-reflective coating, tints, oversized lenses or polycarbonate or Trivex™ must be medically necessary and reasonable to be covered based on Medicare criteria. In addition to the Medicare coverage, this plan covers routine eye exams and may cover routine eyewear as specified in the Chapter 4 Medical Benefits Chart as a supplemental benefit or purchased as part of an optional supplemental benefit package. Refraction vision test is not covered except where covered under supplemental routine eye exam benefit. This is a supplemental benefit. To utilize this benefit you must use a provider who participates in our routine vision provider network or your services will be considered out of network, even if rendered by a medical

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		provider who is not part of the Vendors network.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	**Not covered under any condition.**	
Acupuncture		• Available for people with chronic low back pain under certain circumstances.
Naturopath services (uses natural or alternative treatments).	**Not covered under any condition.**	
Drugs for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.	**Not covered under any condition.**	
Over-the-counter purchases		• Medicare doesn't cover Over-the-counter purchases. This plan covers over-the-counter purchases as specified in the Chapter 4 Benefit Chart as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. If the benefit is available you must utilize the contracted OTC provider, limitations and exclusions may apply.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		territories.
Prescription drugs you buy outside the U.S.	**Not covered under any condition.**	
Services performed by out-of-network providers.		• This plan covers services of out-of-network providers. You are responsible for verifying provider network status prior to receiving services. In-network providers and facilities are listed in the Provider Directory or online at the website listed on the back cover of this booklet. The use of an out-of-network provider will apply the out-of-network provider cost share (even approved) unless considered urgent/emergent (required immediately) or when approved in advance for in-network cost sharing. Please see Chapter 3; Section 2.4 for more information. When utilizing an out-of-network provider, you are not required to obtain prior authorization however are encouraged to do so. If no prior authorization is obtained we will review claims submitted to determine coverage under the Medicare program and you could be held liable if not covered.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services performed by non-participating vendor network providers		• Some supplemental benefits utilize a specific Vendor and providers who participate with that Vendor. Providers that participate with the plan may or may not be associated with that Vendor. You may call the plan prior to services being rendered with any questions. To be covered in network, you must use a provider that participates with that Vendor as identified in the provider directory or your services will be considered out-of-network, even if rendered by a medical provider if they are not part of the Vendors network. There may be other exceptions, see Chapter 3 (Using the plan for your medical services) for more information.
Services ordered or administered that are determined to not be a Medicare covered benefit in accordance with Medicare guidelines and the Social Security Act.		• Section 1833(e) of the Social Security Act prohibits Medicare payment for any request for coverage which lacks the necessary information to process the request. Section 1862(a)(1)(A)of the Social Security Act which excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		functioning of a malformed body member.
Lab, Radiological & Genetic Testing		• We follow Medicare guidelines when determining if Lab, Radiological & Genetic Testing services are covered, even if ordered by a physician. Not all lab, Radiological or genetic testing is covered under the Medicare Program, such as Genetic testing based on family medical history. You have the right to contact the plan prior to services being rendered to determine if the services will be covered for your condition (see Organization Determination). When utilizing an out of network provider, you are not required to obtain prior authorization however are encouraged to do so. If no prior authorization is obtained we will review claims submitted to determine coverage under the Medicare program and you could be held liable if not covered.
Non-emergency ambulance trips		• Medicare does not pay for transportation, including non-emergency ambulance transportation to and from dialysis, unless the Medicare

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		definition of bed-confined is met and documented by your doctor. Bed-confined is defined as unable to get up from bed without assistance; unable to ambulate; and unable to sit in a chair or wheelchair.
Modifications to a member's home such as a stair lift and other devices including bathtub grab bars, special pillows, chairs and other items that do not fall under Medicare-covered durable medical equipment.		• This plan covers Assistive Devices that is offered as a supplemental benefit as specified in the Chapter 4 Benefit Chart. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this MA plan. If the benefit is available you must use a provider who participates in our contracted network.
Items and services administered to a beneficiary for the purpose of causing or assisting in causing death.	**Not covered under any condition.**	
Items and services required as a result of war	**Not covered under any condition.**	
Items and services authorized or paid by a government entity such as Veterans Administration authorized services	**Not covered under any condition.**	
Defective equipment or medical devices covered under warranty.	**Not covered under any condition.**	

CHAPTER 5:

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

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

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

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

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

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

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

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

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

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

- You only have to pay your cost-sharing amount when you get covered services. We do not allow providers to add additional separate charges, called *balance billing*. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this document has information about how to make an appeal.

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

You may request us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within one year** of the date you received the service or item.

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

- You don't have to use the form, but it will help us process the information faster. With your request

include:

- Itemized bill with dates of service and amount charged for each service.
- Receipt of payment.
- Medical records (if the medical records are not written in English, a certified translation of the documents should be provided if available).
- Itinerary (if the services were received on a cruise ship).
- Appointment of Representation (AOR) or Power of Attorney form (if someone other than the member is submitting the request).

- Either download a copy of the form from our website www.anthem.com or call Customer Service and ask for the form.

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

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

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

Section 3.1 We check to see whether we should cover the service and how much we owe

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

- If we decide that the medical care is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider.
- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or the amount we are

paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For details on how to make this appeal, go to Chapter 7 of this document.

CHAPTER 6:

Your rights and responsibilities

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

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Service.

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

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

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Customer Service at 1-855-690-7798 (TTY users should call 711) or by writing us at: Civil Rights Coordinator, Mailstop: OH0205-A537; 4361 Irwin Simpson Rd, Mason, OH 45040. You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in the plan's network. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral and still pay the in-network cost-sharing amount.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9 of this document tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

You have the right to know how your health information has been shared with others for any purposes that

are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service.

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 www.anthem.com 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 Customer Service 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 www.anthem.com/privacy for more information.

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

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

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

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

You have the right and choice to tell us to:

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

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

Other reasons we may use or share your information:

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

- Helping with public health and safety issues, such as:
    - Preventing disease
    - Helping with product recalls

  - Reporting adverse reactions to medicines
  - Reporting suspected abuse, neglect or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- Doing health research.
- Obeying the law, if it requires sharing your information.
- Responding to organ donation groups for research and certain reasons.
- Addressing 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 Customer Service 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 your 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.anthem.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 Customer Service 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.

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

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

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

As a member of Anthem Veteran (PPO), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, please call Customer Service:

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

Section 1.5 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by

our plan.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. Of course, if you refuse treatment, you accept full responsibility for what happens to your body as a result.

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

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

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

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

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

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

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

- The hospital will ask you whether you have signed an advance directive form and whether you have

it with you.

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the The Missouri Bar.

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

If you have any problems, concerns, or complaints and need to request coverage, or make an appeal, Chapter 7 of this document tells what you can do. Whatever you do–ask for a coverage decision, make an appeal, or make a complaint–**we are required to treat you fairly.**

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

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

- You can **call Customer Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
  - Or you can call, 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

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

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other

offices.

- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
  - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move outside of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 7:

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

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

- Uses simpler words in place of certain legal terms. For example, this chapter generally says, making a complaint rather than filing a grievance, coverage decision rather than organization determination and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

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

SECTION 2 Where to get more information and personalized assistance

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or

with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes.

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

No.

Skip ahead to **Section 9** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions prior to receiving benefits

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the

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

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

- You do not need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we do not fully agree with your Level 1 appeal.
- See **Section 5.4** of this chapter for more information about Level 2 appeals.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 8 in this chapter explains the Level 3, 4, and 5 appeals processes).

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

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

- You **can call us at Customer Service**.
- You **can get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they will need to be appointed as your representative. Please call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)
    - For medical care or Part B prescription drugs, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your *representative* to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or another person to be your representative, call Customer Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare's website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be

signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.

- While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

- **You also have the right to hire a lawyer.** You may contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

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

If you're not sure which section you should be using, please call Customer Service. You can also get help or information from government organizations such as your SHIP.

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

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

This section is about your benefits for medical care. These benefits are described in Chapter 4 of this document: *Medical Benefits Chart (what is covered and what you pay)*. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for

Part B prescription drugs are different from the rules for medical items and services.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan. **Ask for a coverage decision. Section 5.2.**
3. You have received medical care that you believe should be covered by the plan, but we have said we will not pay for this care. **Make an Appeal. Section 5.3.**
4. You have received and paid for medical care that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an Appeal. Section 5.3.**

   Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read Sections 6 and 7 of this Chapter. Special rules apply to these types of care.

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

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

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

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

- You may *only ask* for coverage for medical care items and/or services (not requests for payment for items and/or services already received).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a fast coverage decision, we will**

automatically agree to give you a fast coverage decision.

- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested.

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

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

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

For standard coverage decisions we use the standard deadlines.

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

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

For Fast Coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take

extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 9 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

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

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

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

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

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

- If you are appealing a decision, we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a *fast appeal*. If your doctor tells us that your health requires a *fast appeal*, we will give you a fast appeal.
- The requirements for getting a *fast appeal* are the same as those for getting a *fast coverage decision* in Section 5.2 of this chapter.

Step 2: Ask our plan for an Appeal or a Fast Appeal

If you are asking for a standard appeal, submit your standard appeal in writing. Chapter 2 has contact information.

- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your

appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.** We are allowed to charge a fee for copying and sending this information to you.

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if your health condition requires us to.

- However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
- If we do not give you an answer by the deadline (or by the end of the extended time period), we will send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal,** we will automatically send your appeal to the independent review organization for a Level 2 appeal.

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

Legal Term
The formal name for the independent review organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

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

Step 1: The independent review organization reviews your appeal.

- We will send the information about your appeal to this organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

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

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

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

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision. It is also called turning down your appeal.) In this case, the independent review organization will send you a letter:

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you are asking for a coverage decision. To make this coverage decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we receive your request. If you haven't paid for the medical care, we will send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals that we describe in Section 5.3. For appeals

concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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

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

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

- The day you leave the hospital is called your **discharge date**.
- When your discharge date is decided, your doctor or the hospital staff will tell you.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

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

Within two calendar days of being admitted to the hospital, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you about:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.

- Where to report any concerns you have about the quality of your hospital care.
- Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.

2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.
3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Customer Service or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 6.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

The **Quality Improvement Organization** is a group of doctors and other health care professionals who are paid by the Federal government to check on and help improve the quality of care for people with Medicare.

These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**
    - If you meet this deadline, you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
    - If you do *not* meet this deadline, contact us. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Customer Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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

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

date.

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

- If the Quality Improvement Organization has said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to Level 2 of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

- Reviewers at the Quality Improvement Organization will take another careful look at all of the

information related to your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process.

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

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

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

Section 7.1 *This section is only about three services:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

When you are getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care*.

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

Section 7.2 We will tell you in advance when your coverage will be ending

Legal Term
Notice of Medicare Non-Coverage. It tells you how you can request a **fast-track appeal.** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care.

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

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help at any time, please call Customer Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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

The **Quality Improvement Organization** is a group of doctors and other health care experts "who are" paid by the Federal government to check on and improve the quality of care for people with Medicare. This

includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

Legal Term
Detailed Explanation of Non-Coverage. Notice that provides details on reasons for ending coverage.

What happens during this review?

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

Step 3: Within one full day after they have all the information they need; the reviewers

will tell you their decision.

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

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

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your appeal request, reviewers will decide

on your appeal and tell you their decision.

What happens if the review organization says yes?

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

What happens if the review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator.

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

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

Level 3 appeal	**An Administrative Law Judge or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may* or *may not* be over.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that is favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
    - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after receiving the Administrative Law Judge's or attorney adjudicator's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.
- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

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

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

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

MAKING COMPLAINTS

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Customer Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Customer Service or other staff at the plan? ○ Examples include waiting too long on the phone, in the waiting or exam room.

Complaint	Example
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 9.2 How to make a complaint

Legal Terms

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do,

Customer Service will let you know.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.**If you put your complaint in writing, we will respond to your complaint in writing.
    - You or someone you name may file a grievance. The person you name would be your representative. You may name a relative, friend, lawyer, advocate, doctor or anyone else to act for you.
    - If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.
    - A grievance must be filed, either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or, if we justify a need for additional information and the delay is in your best interest.
    - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or, if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If you are making a complaint because we denied your request for a fast coverage decision or a fast appeal, we will automatically give you a fast complaint.** If you have a fast complaint, it means we will give you **an answer within 24 hours.**
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will include our reasons in our response to you.

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

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

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

Or

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

Section 9.5 You can also tell Medicare about your complaint

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

CHAPTER 8:

Ending your membership in the plan

SECTION 1 Introduction to ending your membership in our plan

Ending your membership in Anthem Veteran (PPO) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

Section 2.1 You can end your membership during the Annual Enrollment Period

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

- **The Annual Enrollment Period** is from **October 15 to December 7.**
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without prescription drug coverage,
  - Original Medicare *with* a separate Medicare prescription drug plan,
  - - *or* - Original Medicare *without* a separate Medicare prescription drug plan.
- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period.**

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement

to Part A and Part B until the last day of the 3rd month of entitlement.

- **During the annual Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

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

You may be eligible to end your membership during a Special Enrollment Period if any of the following situations apply to you. These are just examples; for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved
- If you have Medicaid
- If we violate our contract with you
- If you get care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

- Another Medicare health plan with or without prescription drug coverage,
- Original Medicare *with* a separate Medicare prescription drug plan,

- – or – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

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

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

- **Call Customer Service**.
- Find the information in the ***Medicare & You 2025*** handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

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

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

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Anthem Veteran (PPO) when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Anthem Veteran (PPO) when your new plan's coverage begins.

If you would like to switch from our plan to:	This is what you should do:
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll**. Contact Customer Service if you need more information on how to do this. • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Anthem Veteran (PPO) when your coverage in Original Medicare begins.

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

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

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

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

SECTION 5 Anthem Veteran (PPO) must end your membership in the plan in certain situations

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

Anthem Veteran (PPO) must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.

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

Where can you get more information?

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

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

Anthem Veteran (PPO) is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership.

CHAPTER 9:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at https://www.hhs.gov/ocr/index.html.

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

Nondiscrimination Notice

Discrimination is against the law. Anthem Veteran (PPO) follows State and Federal civil rights laws. Anthem Veteran (PPO) does not unlawfully discriminate, exclude people, or treat them differently because of sex, race, color, national origin, age, or disability.

Anthem Veteran (PPO):

- Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language assistance services to people whose primary language is not English, which

may include:

- Qualified interpreters
- Information written in other languages.

If you need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the plan's Compliance Coordinator. If you believe that Anthem Veteran (PPO) has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by phone, in writing, or electronically:

- By phone: Contact the Compliance Coordinator between 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 by calling **1-855-690-7798**. Or, if you cannot hear or speak well, please call **711**.
- In writing: Fill out a complaint form or write a letter and send it to:

  Anthem Veteran (PPO)
  Medicare Complaints, Appeals & Grievances
  Mailstop: OH0205-A537
  4361 Irwin Simpson Rd
  Mason, OH 45040

- Electronically: Visit the plan's website at: www.anthem.com

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

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Anthem Veteran (PPO), as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

Additional Legal notices

Collecting member payments

Under certain circumstances, if we pay the health care provider amounts that are your responsibility, such as deductibles, copayments or coinsurance, we may collect such amounts directly from you. You agree that we have the right to collect such amounts from you.

Assignment

The benefits provided under this *Evidence of Coverage* are for the personal benefit of the member and cannot be transferred or assigned. Any attempt to assign this contract will automatically terminate all rights under this contract.

Notice of claim

In the event that a service is rendered for which you are billed, you have at least 12 months from the date of service to submit such claims to your plan. According to CMS Pub 100-02 Benefit Policy, Chapter 15, Section 40, physicians and practitioners are required to submit claims on behalf of beneficiaries for all items and services they provide for which Medicare payment may be made under Part B. Also, they **are not allowed to charge beneficiaries in excess of the limits on charges that apply to the item or service being furnished**. However, a physician or practitioner (as defined in §40.4) may opt out of Medicare. A physician or practitioner who opts out is not required to submit claims on behalf of beneficiaries and also is excluded from limits on charges for Medicare covered services.

You may submit such claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Entire contract

This *Evidence of Coverage* and applicable riders attached hereto, and your completed enrollment form, constitute the entire contract between the parties and as of the effective date hereof, supersede all other agreements between the parties.

Waiver by agents

No agent or other person, except an executive officer of Anthem Blue Cross and Blue Shield, has authority to waive any conditions or restrictions of this *Evidence of Coverage* or the Medical Benefits Chart in Chapter 4. No change in this *Evidence of Coverage* shall be valid unless evidenced by an endorsement signed by an authorized executive officer of the company or by an amendment to it signed by the

authorized company officer.

Cessation of operation

In the event of the cessation of operation or dissolution of your plan in the area in which you reside, this *Evidence of Coverage* will be terminated. You will receive notice 90 days before the *Evidence of Coverage* is terminated. **Please note:** If the *Evidence of Coverage* terminates, your coverage will also end.

In that event, the company will explain your options at that time. For example, there may be other health plans in the area for you to join if you wish. Or you may wish to return to Original Medicare and possibly obtain supplemental insurance. In the latter situation, Anthem Blue Cross and Blue Shield would arrange for you to obtain, without health screening or a waiting period, a supplemental health insurance policy to cover Medicare coinsurance and deductibles.

Whether you enroll in another prepaid health plan or not, there would be no gap in coverage.

Refusal to accept treatment

You may, for personal or religious reasons, refuse to accept procedures or treatment recommended as necessary by your primary care physician. Although such refusal is your right, in some situations it may be regarded as a barrier to the continuance of the provider/patient relationship, or to the rendering of the appropriate standard of care.

When a member refuses a recommended, necessary treatment or procedure, and the primary care physician believes that no professionally acceptable alternative exists, the member will be advised of this belief.

In the event you discharge yourself from a facility against medical advice, your plan will pay for covered services rendered up to the day of self-discharge. Fees pertaining to that admission will be paid on a per diem basis or appropriate Diagnostic Related Grouping (DRG), whichever is applicable.

Limitations of actions

No legal action may be taken to recover benefits within 60 days after the service is rendered. No such action may be taken later than three years after the service, upon which the legal action is based, was provided.

Circumstances beyond plan control

If there is an epidemic, catastrophe, general emergency, or other circumstance beyond the company’s control, neither your plan nor any provider shall have any liability or obligation except the following, as a result of reasonable delay in providing services:

- Because of the occurrence, you may have to obtain covered services from a non-network provider, instead of a network provider. Your plan will reimburse you up to the amount that would have been covered under this *Evidence of Coverage*.

- Your plan may require written statements, from you and the medical personnel who attended you, confirming your illness or injury and the necessity for the treatment you received.

Plan's sole discretion

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

This applies if the plan determines such services and supplies are in lieu of more expensive services and supplies that would otherwise be required for the care and treatment of a member.

Disclosure

You are entitled to ask for the following information from your plan:

- Information on your plan's physician incentive plans.
- Information on the procedures your plan uses to control utilization of services and expenditures.
- Information on the financial condition of the company.
- General coverage and comparative plan information.

To obtain this information, call Customer Service at 1-855-690-7798, or, if you are hearing or speech impaired and have a TTY telephone line, 711. The Customer Service department is available from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The plan will send this information to you within 30 days of your request.

Information about advance directives

(Information about using a legal form such as a “living will” or “power of attorney” to give directions in advance about your health care in case you become unable to make your own health care decisions).

You have the right to make your own health care decisions. *But what if you had an accident or illness so serious that you became unable to make these decisions for yourself?*

If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both - to appoint someone else to make decisions for you, and to let this person and your health care providers know the kinds of medical care you would want if you were

unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an “advance directive,” because it lets you give directions in advance about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called “living will” and “power of attorney for health care” are examples of advance directives.

It's your choice whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether or not you have an advance directive.

How can you use a legal form to give your instructions in advance?

If you decide that you want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program). Chapter 2 of this document tells how to contact your SHIP. SHIPs have different names depending on which state you are in.

Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't.

You may want to give copies to close friends or family members as well. If you know ahead of time that you are going to be hospitalized, take a copy with you.

If you are hospitalized, they will ask you about an advance directive

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

It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if providers don't follow the instructions you have given?

If you believe that a doctor or hospital has not followed the instructions in your advance directive, you may file a complaint with your state Department of Health.

Continuity and coordination of care

Anthem Blue Cross and Blue Shield has policies and procedures in place to promote the coordination and continuity of medical care for our members. This includes the confidential exchange of information between primary care physicians and specialists, as well as behavioral health providers. In addition, Anthem Blue Cross and Blue Shield helps coordinate care with a practitioner when the practitioner's contract has been discontinued and works to enable a smooth transition to a new practitioner.

Subrogation and reimbursement

These provisions apply when we pay benefits as a result of injuries or illness you sustained, and you have a right to a recovery or have received a recovery. We have the right to recover payments we make on your behalf, or take any legal action against, any party responsible for compensating you for your injuries. We also have a right to be repaid from any recovery in the amount of benefits paid on your behalf. The following apply:

- The amount of our recovery will be calculated pursuant to 42 C.F.R. 411.37, and pursuant to 42 C.F.R. 422.108(f), no state laws shall apply to our subrogation and reimbursement rights.
- Our subrogation and reimbursement rights shall have first priority, to be paid before any of your other claims are paid. Our subrogation and reimbursement rights will not be affected, reduced, or eliminated by the "made whole" doctrine or any other equitable doctrine.
- You must notify us promptly of how, when and where an accident or incident, resulting in personal injury or illness to you, occurred and all information regarding the parties involved, and you must notify us promptly if you retain an attorney related to such an accident or incident. You and your legal representative must cooperate with us, do whatever is necessary to enable us to exercise our rights, and do nothing to prejudice our rights.
- If you fail to repay us, we shall be entitled to deduct any of the unsatisfied portion of the amount of benefits we have paid or the amount of your recovery whichever is less, from any future benefit under the plan.

Presidential or Gubernatorial emergencies

In the event of a Presidential or Gubernatorial emergency or major disaster declaration or an announcement of a public health emergency by the Secretary of Health and Human Services, your plan will make the following exceptions to assure adequate care during the emergency:

- Approve services to be furnished at specified non-contracted facilities that are considered Medicare-certified facility;
- Temporarily reduce cost sharing for plan-approved out-of-network services to the in-network cost-sharing amounts; and

- Waive in full the requirements for a primary physician referral where applicable.

Typically, the source that declared the disaster will clarify when the disaster or emergency is over. If, however, the disaster or emergency time frame has not been closed within 30 days from the initial declaration, and, if CMS has not indicated an end date to the disaster or emergency, your plan will resume normal operations 30 days from the initial declaration.

When a disaster or emergency is declared, it is specific to a geographic location (i.e., county). Your plan will apply the above exceptions only if you reside in the geographic location indicated.

CHAPTER 10:

Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

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

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

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of Anthem Veteran (PPO), you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to *balance bill* or otherwise charge you more than the amount of cost sharing your plan says you must pay.

Benefit Period – The way that Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

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

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

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.2, for information about your combined maximum out-of-pocket amount.

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

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

evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount (for example $10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed *copayment* amount that a plan requires when a specific service is received; or (3) any *coinsurance* amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The term we use in this EOC to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care provided by people who do not have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

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

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

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you are a pregnant woman, loss of an unborn child), loss of

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

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

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

"Extra Help" – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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

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

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an *outpatient.*

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider.

Low Income Subsidy (LIS) – See "Extra Help."

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

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. This plan does not offer Medicare prescription drug coverage.

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

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

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill **gaps** in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Network Provider – **Provider** is the general term for doctors, other health care professionals, hospitals,

and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called *plan providers*.

Optional Supplemental Benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. You must voluntarily elect Optional Supplemental Benefits in order to get them.

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

Original Medicare (**Traditional Medicare** or **Fee-for-Service Medicare**) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for *cost sharing* above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's *out-of-pocket* cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred)

providers.

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

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets *prior authorization* from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4.

Prosthetics and Orthotics –Medical devices including, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan must disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social

Security benefits.

Urgently Needed Services – A plan-covered service requiring immediate medical attention that is not an emergency is an urgently needed service if either you are temporarily outside the service area of the plan, or it is unreasonable given your time, place, and circumstances to obtain this service from network providers with whom the plan contract. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits, such as annual checkups, are not considered urgently needed even if you are outside the service area of the plan or the plan network is temporarily unavailable.

Form Approved
OMB# 0938-1421

Multi-Language Insert
Multi-Language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at **1-855-690-7798** (TTY: **711**). Someone who speaks English can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al **1-855-690-7798** (TTY: **711**). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险 的任 何疑问。 如果您需要此翻译服务，请致电 **1-855-690-7798** (TTY: **711**)。
我们的中文工作人员很乐意帮 助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有 疑問，為此我們提供免 費的 翻譯服務。 如需翻譯服務， 請致 **1-855-690-7798** (TTY: **711**)。 我們講中文的人員將樂意為您提供幫助。 這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa **1-855-690-7798** (TTY: **711**). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au **1-855-690-7798** (TTY: **711**). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi **1-855-690-7798** (TTY: **711**) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter **1-855-690-7798** (TTY: **711**). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제 공하고 있습니다. 통역 서비스를 이용하려면 전화 **1-855-690-7798** (TTY: **711**) 번으로 문의해 주십시오. 한국 어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону **1-855-690-7798** (TTY: **711**). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم, فوري ليس عليك سوى الاتصال بنا على (TTY: **711**) **1-855-690-7798**.
سيقوم شخص ما يتحدثالعربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें **1-855-690-7798** (TTY: **711**) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero **1-855-690-7798** (TTY: **711**). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número **1-855-690-7798** (TTY: **711**). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan **1-855-690-7798** (TTY: **711**). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer **1-855-690-7798** (TTY: **711**). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関 するご質問にお答えするため に、無料の通訳サービスがあり ますございます。 通訳をご 用命になるには、 **1-855-690-7798** (TTY: **711**) にお電話ください。 日本語を話す人 者 が支援いたします。
これは無料のサービスです。

Anthem Blue Cross and Blue Shield is an PPO plan with a Medicare contract. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. In Missouri (excluding 30 counties in the Kansas City area): Anthem Blue Cross and Blue Shield is the trade name of RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent licensees of the Blue Cross Blue Shield Association. Anthem is a registered trademark of Anthem Insurance Companies, Inc.

The Benefits Mastercard® Prepaid Card is issued by The Bancorp Bank N.A., Member FDIC, pursuant to license by Mastercard International Incorporated and card can be used for eligible expenses wherever Mastercard is accepted. Valid only in the U.S. No cash access. This is not a gift card or gift certificate. You have received this card as a gratuity without the payment of any monetary value or consideration.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Anthem Veteran (PPO) Customer Service

Method	Customer Service – Contact Information
CALL	1-855-690-7798 (Calls to this number are free.) Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Customer Service 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.
FAX	1-877-664-1504
WRITE	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com

Missouri State Health Insurance Assistance Program (SHIP)

Missouri State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-390-3330 9 a.m. - 4 p.m. local time, Monday - Friday
TTY	711
WRITE	State Health Insurance Assistance Program 601 W Nifong Blvd, Suite 3A Columbia, MO 65203
WEBSITE	http://missouriclaim.org/