Anthem

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug coverage as a Member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

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

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

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

For questions about this document, call Customer Service at 1-877-269-5706. (TTY users 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 HealthPlus Full Dual Advantage LTSS (HMO D-SNP), 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 HealthPlus Full Dual Advantage LTSS (HMO D-SNP).)

This document is available for free in Spanish.

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, deductibles, and/or copayments or coinsurance may change on January 1, 2027.

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

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OMB Approval 0938-1051
(Expires: August 31, 2026)

2026 Evidence of Coverage

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CHAPTER 1:

Get started as a member

SECTION 1 You're a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

Section 1.1 You're enrolled in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), which is a Medicare Special Needs Plan

You're covered by both Medicare and Medicaid:

- **Medicare** is 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 (kidney failure).
- **Medicaid** is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Medicaid coverage varies depending on the state and the type of Medicaid you have. Some people with Medicaid get help paying for their Medicare premiums and other costs. Other people also get coverage for additional services and drugs that aren't covered by Medicare.

You've chosen to get your Medicare and Medicaid health care and your drug coverage through our plan, Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). Our plan covers all Part A and Part B services. However, cost sharing and provider access in our plan differ from Original Medicare.

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is a specialized Medicare Advantage Plan (a Medicare Special Needs Plan), which means benefits are designed for people with special health care needs. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is designed for people who have Medicare and are entitled to help from Medicaid.

Because you get help from Medicaid with Medicare Part A and B cost sharing (deductibles, copayments, and coinsurance), you may pay nothing for your Medicare services. Medicaid may also provide other benefits by covering health care services that aren't usually covered under Medicare. Your coverage under New York State Medicaid provides coverage for Medicare premiums, deductibles and cost sharing applied to covered Medicare services and for additional Medicaid benefits as per state guidelines. You may also receive "Extra Help" from Medicare to pay for the costs of your Medicare prescription drugs. Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will help you manage all of these benefits, so you get the health services and payment help that you're entitled to.

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is run by a private company. Like all Medicare Advantage Plans, this Medicare Special Needs Plan is approved by Medicare. The plan also has a contract with the New York Medicaid program to coordinate your Medicaid benefits. We're pleased to provide your Medicare and Medicaid coverage, including drug coverage.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to our plans we offer each year. This means we can change the costs and benefits of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

Medicare (the Centers for Medicare & Medicaid Services) and New York State Medicaid Program must approve Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue offering our plan and Medicare renews approval of our plan.

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B
- You live in our geographic service area (described in Section 2.3). People who are incarcerated aren't considered to be living in the geographic service area even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.
- You meet the special eligibility requirements described below.

Special eligibility requirements for our plan

Our plan is designed to meet the needs of people who get certain Medicaid benefits. (Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited

incomes and resources.)You are eligible to join Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) if you have Medicare, full Medicaid and:

- Are age 18 and older
- Reside in the plan's service area
- Have a chronic illness or disability that makes you eligible for nursing home level of care at the time of enrollment
- Are able to stay safely at home at the time you join the plan
- The member is expected to need at least one (1) of the following community-based long-term-care services (CBL TCS) covered by Medicaid Advantage Plus product for more than 120 days from the effective date of enrollment:
  - Nursing services in the home
  - Therapies in the home
  - Home health aide services
  - Personal care services in the home
  - Adult day health care
  - Private-duty nursing
  - Consumer-directed personal assistant services
- Participation in the Medicaid Advantage Plus program and enrollment in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is voluntary for all eligible persons.

Note: If you lose your eligibility but can reasonably be expected to regain eligibility within 6-month(s), then you're still eligible for membership. Chapter 4, Section 2 tells you about coverage and cost sharing during a period of deemed continued eligibility.

Section 2.2 Medicaid

Medicaid is a joint federal and state government program that helps with medical and long-term care costs for certain people who have limited incomes and resources. Each state decides what counts as income and resources, who's eligible, what services are covered, and the cost for services. States also can decide how to run its program as long as they follow the federal guidelines.

In addition, Medicaid offers programs to help people pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). QMB+ are also eligible for full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** An individual who is not QMB or SLMB, but is eligible for full Medicaid benefits either categorically or through optional coverage groups.

Section 2.3 Plan service area for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our plan service area. The service area is described below.

Our service area includes these counties in New York: Bronx, Kings, Nassau, New York, Orange, Queens, Richmond, Rockland, Suffolk, Westchester.

If you plan to move to a new state, you should also contact your state's Medicaid office and ask how this move will affect your Medicaid benefits. Phone numbers for Medicaid are in Chapter 2, Section 6 of this document.

If you move out of our plan's service area, you can't stay a member of this plan. Call Customer Service at 1-877-269-5706 (TTY users call 711) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

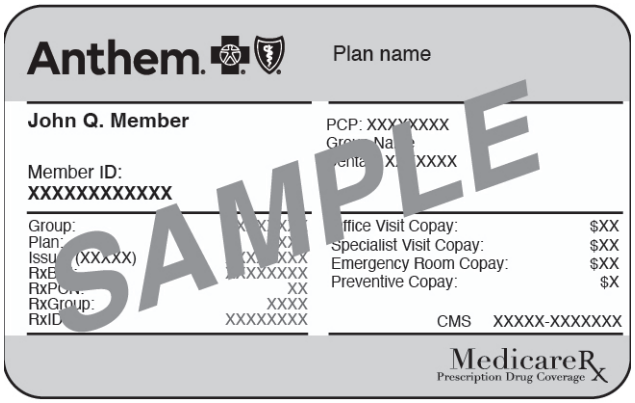
Section 2.4 U.S. citizen or lawful presence

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

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card. Sample membership card:



DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) 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 our plan membership card is damaged, lost, or stolen, call Customer Service at 1-877-269-5706 (TTY users call 711) right away and we'll send you a new card.

Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* www.anthem.com 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.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is situations where it's unreasonable or not possible to get services in-network), out-of-area dialysis services, and cases when Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) authorizes use of out-of-network providers.

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

The *Provider/Pharmacy Directory* www.anthem.com lists our network pharmacies. **Network pharmacies** are all of the pharmacies that have agreed to fill covered prescriptions for our plan

members. Use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.4 for information on when you can use pharmacies that are not in the plan's network.

If you don't have a *Provider/Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Customer Service at 1-877-269-5706 (TTY users call 711). Requested paper *Provider/Pharmacy Directory* will be mailed to you within 3 business days.

Section 3.3 Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved the Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit www.anthem.com or call Customer Service at 1-877-269-5706 (TTY users call 711).

SECTION 4 Your monthly costs for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

	Your Costs in 2026
Monthly plan premium* * Your premium can be higher than this amount. Go to Section 4.1 for details.	$0.00
Maximum out-of-pocket amount This is the most you'll pay out of pocket for covered Part A and Part B services. (Go to Chapter 4 for details.)	$9,250.00 You are not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

	Your Costs in 2026
Primary care office visits	$0.00 copay **per visit**
Specialist office visits	$0.00 copay **per visit**
Inpatient hospital stays	$0.00 copay per stay
Part D drug coverage deductible (Go to Chapter 6 Section 4 for details.)	Deductible: **If you receive Extra Help, this payment stage doesn't apply to you.** **If you do <u>not</u> qualify for Extra Help,** the deductible is **$615.00** (**Tier** 2: Generic, **Tier** 3: Preferred Brand, **Tier** 4: Non-Preferred Drug, and **Tier** 5: Specialty Tier) except for covered insulin products and most adult Part D vaccines.
Part D drug coverage (Go to Chapter 6 Section 4 for details, including Yearly Deductible, Initial Coverage, and Catastrophic Coverage Stages.) *The amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage and whether you use a generic or brand drug. Please refer to your LIS Rider for your specific copayment amount.	**If you receive Extra Help,** Copayment/Coinsurance during the **Initial Coverage Stage**: • **Drug Tier 1** - Preferred Generic**:** $0.00 per prescription. • **Drug Tier 2** - Generic**:** $0.00 - $12.65* per prescription. • **Drug Tier 3** - Preferred Brand**:** $0.00 - $12.65* per prescription. You pay $0.00 - $12.65* per month supply of each covered insulin product on this tier. • **Drug Tier 4** - Non-Preferred Drug**:** $0.00 - $12.65* per prescription.

	Your Costs in 2026
	• **Drug Tier 5** - Specialty Tier**:** $0.00 - $12.65* per prescription. • **Drug Tier 6** - Select Care Drugs**:** $0.00 per prescription. **If you do <u>not</u> qualify for Extra Help,** Copayment/Coinsurance during the Initial Coverage Stage: • **Drug Tier 1** - Preferred Generic**:** $0.00 copayment • **Drug Tier 2** - Generic**:** 25% coinsurance • **Drug Tier 3** - Preferred Brand**:** 25% coinsurance You won't pay more than $35.00 per month supply of each covered insulin product on this tier. • **Drug Tier 4** - Non-Preferred Drug**:** 25% coinsurance • **Drug Tier 5** - Specialty Tier**:** 25% coinsurance • **Drug Tier 6** - Select Care Drugs**:** $0.00 copayment **Catastrophic Coverage Stage:** • During this payment stage, you pay nothing for your covered Part D drugs**.**

Your costs may include the following:

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

- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 Plan premium

You don't pay a separate monthly plan premium for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP).

If you already get help from one of these programs, **the information about premiums in this *Evidence of Coverage* may not apply to you.** We sent you a separate document, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, please call Customer Service 1-877-269-5706 (TTY users call 711) and ask for the *LIS Rider*.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

Some members are required to pay other Medicare premiums. As explained in Section 2 above, to be eligible for our plan, you must maintain your eligibility for Medicaid as well as have both Medicare Part A and Medicare Part B. For most Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) members, Medicaid pays for your Part A premium (if you don't qualify for it automatically) and Part B premium.

If Medicaid isn't paying your Medicare premiums for you, you must continue to pay your Medicare premiums to stay a member of our plan. This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Because you're dually-eligible, the LEP doesn't apply as long as you maintain your dually-eligible status, but if you lose your dually-eligible status, you may incur an LEP. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or a newsletter from that plan. Keep this information, because you may need it if you join a Medicare drug plan later.
    - **Note**: Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
    - **Note**: Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- First, count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months you didn't have creditable drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary and round it to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.46. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year,** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're *under* 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Important: Don't stop paying your Part D late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay our plan premiums.

Section 4.4 Income Related Monthly Adjustment Amount

If you lose eligibility for this plan because of changes to income, some members may be required to pay an extra charge for their Medicare plan, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

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

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

Section 4.5 Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, each month you'll pay our plan premium (if you have one) and you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

SECTION 5 More information about your monthly plan premium

Section 5.1 Our monthly plan premium won't change during the year

We're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we'll tell you in September, and the new premium will take effect on January 1.

However, in some cases, you may be able to stop paying a late enrollment penalty, if you owe one, or you may need to start paying a late enrollment penalty. This could happen if you become eligible for Extra Help or lose your eligibility for Extra Help during the year.

- If you currently pay a Part D late enrollment penalty and become eligible for Extra Help during the year, you'd be able to stop paying your penalty.
- If you lose Extra Help, you may be subject to the Part D late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

Find out more about Extra Help in Chapter 2, Section 7.

SECTION 6 Keep our plan membership record up to date

Your membership record has information from your enrollment form, including your address and phone number. It shows your specific plan coverage including your Primary Care Provider (PCP).

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost-sharing amounts**. Because of this, it's very important to help us keep your information up to date.

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

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

If any of this information changes, let us know by calling Customer Service 1-877-269-5706 (TTY users call 711).

It’s also important to contact Social Security if you move or change your mailing address. Call Social Security at 1-800-772-1213 (TTY users call 1-800-325-0778).

SECTION 7 How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we’ll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don’t need to do anything. If the information isn’t correct, or if you have other coverage that’s not listed, call Customer Service 1-877-269-5706 (TTY users call 711). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

CHAPTER 2:

Phone numbers and resources

SECTION 1 Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) contacts

For help with claims, billing, or member card questions, call or write to Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Customer Service. We'll be happy to help you.

Customer Service – Contact Information	
Call	1-877-269-5706 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. Customer Service 1-877-269-5706 (TTY users call 711) also has free language interpreter services 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 1407 Church Street Station New York, NY 10008-1407
Website	www.anthem.com

How to ask for a coverage decision or appeal about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we pay for your medical services or Part D drugs. An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for coverage decisions or appeals about your medical care or Part D drugs, go to Chapter 9.

Coverage Decisions for Medical Care – Contact Information	
Call	1-877-269-5706 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 1407 Church Street Station New York, NY 10008-1407
Website	https://shop.anthem.com/medicare

Coverage Decisions for Part D drugs – Contact Information	
Call	1-833-344-1010 Calls to this number are free. 24 hours a day, 7 days a week
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week
Fax	1-844-521-6938
Write	Anthem Blue Cross and Blue Shield Attention: Pharmacy Department P.O. Box 47686 San Antonio, TX 78265-8686

Coverage Decisions for Part D drugs – Contact Information	
Website	https://shop.anthem.com/medicare

Appeals for Medical Care – Contact Information	
Call	1-877-269-5706 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	1-888-458-1406
Write	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Website	https://shop.anthem.com/medicare

Appeals for Part D drugs – Contact Information	
Call	1-833-344-1010 Calls to this number are free. Hours are 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, seven days a week.

Appeals for Part D drugs – Contact Information	
Fax	1-888-458-1407
Write	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Website	https://shop.anthem.com/medicare

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your medical care, go to Chapter 9.

Complaints about Medical Care – Contact Information	
Call	1-877-269-5706 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
Medicare website	To submit a complaint about Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

Complaints about Part D drugs – Contact Information	
Call	1-833-344-1010 Calls to this number are free. Hours are 24 hours a day, seven days a week.
TTY	711 Calls to this number are free. Hours are 24 hours a day, seven days a week.
Fax	1-888-458-1407
Write	Medicare Complaints, Appeals & Grievances Mailstop: OH0205-A537 4361 Irwin Simpson Rd Mason, OH 45040
Medicare website	To submit a complaint about Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) directly to Medicare, go to www.Medicare.gov/my/medicare-complaint.

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

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

Payment Requests for Medical Care – Contact Information	
Call	1-877-269-5706 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.

Payment Requests for Medical Care – Contact Information	
	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 1407 Church Street Station New York, NY 10008-1407
Website	www.anthem.com

Payment Requests for Part D drugs – Contact Information	
Call	1-833-344-1010 Calls to this number are free. 24 hours a day, 7 days a week
TTY	711 Calls to this number are free. 24 hours a day, 7 days a week
Write	CarelonRx Claims Department - Part D Services P.O. Box 52077 Phoenix, AZ 85072-2077
Website	www.anthem.com

SECTION 2 Get help from Medicare

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

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (CMS). This agency contracts with Medicare Advantage organizations including our plan.

Medicare – Contact Information	
Call	1-800-MEDICARE (1-800-633-4227) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
Chat Live	Chat live at www.Medicare.gov/talk-to-someone.
Write	Write to Medicare at PO Box 1270, Lawrence, KS 66044
Website	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). **To submit a complaint to Medicare,** go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In New York, the SHIP is called New York Health Insurance Information, Counseling and Assistance Program (HIICAP).

New York Health Insurance Information, Counseling and Assistance Program (HIICAP) is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

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

	New York Health Insurance Information, Counseling and Assistance Program (HIICAP) – Contact Information
Call	1-800-701-0501 8:30 a.m. - 5 p.m. local time, Monday - Friday
TTY	711
Write	New York State Office for the Aging 2 Empire State Plaza 5th Floor Albany, NY 12223
Website	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For New York, the Quality Improvement Organization is called Commence Health - New York's Quality Improvement Organization.

Commence Health - New York's Quality Improvement Organization has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people

with Medicare. Commence Health - New York's Quality Improvement Organization is an independent organization. It’s not connected with our plan.

Contact Commence Health - New York's Quality Improvement Organization in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

	Commence Health - New York's Quality Improvement Organization – Contact Information
Call	1-866-815-5440 9 a.m. - 5 p.m. local time, Monday - Friday; 10 a.m. - 4 p.m. local time, Saturday - Sunday
TTY	711
Write	Commence Health PO Box 2687 Virginia Beach, VA 23450
Website	https://www.livantaqio.cms.gov/en

SECTION 5 Social Security

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

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

Social Security– Contact Information	
Call	1-800-772-1213 Calls to this number are free.

Social Security– Contact Information	
	Available 8 am to 7 pm, Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 am to 7 pm, Monday through Friday.
Website	www.SSA.gov

SECTION 6 Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These Medicare Savings Programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary Plus (QMB+):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). QMB+ are also eligible for full Medicaid benefits.
- **Full Benefit Dual Eligible (FBDE):** An individual who is not QMB or SLMB, but is eligible for full Medicaid benefits either categorically or through optional coverage groups.

If you have questions about the help you get from Medicaid, contact New York State Medicaid Program.

	New York State Medicaid Program Program – Contact Information
Call	1-800-541-2831 Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM
TTY	711
Write	New York State Medicaid State Plan One Commerce Plaza, Room 1432

	New York State Medicaid Program Program – Contact Information
	99 Washington Avenue Albany, NY 12210-2808 You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: www.health.ny.gov/health_care/medicaid/ldss
Website	https://www.health.ny.gov/health_care/medicaid/

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

	The New York State Long-Term Care Ombudsman Program – Contact Information
Call	1-855-582-6769 Mon.-Fri. 9:00 AM – 5:00 PM
TTY	711
Write	State LTC Ombudsman New York State Office for the Aging 2 Empire State Plaza, 5th Floor Albany, NY 12223
Email	ombudsman@aging.ny.gov
Website	https://aging.ny.gov/long-term-care-ombudsman-program

	Community Health Access to Addiction and Mental Healthcare Project (CHAMP) – Contact Information
Call	1-888-614-5400 Mon.-Wed. 9:00 AM – 7:00 PM, Thurs.-Fri. 9:00 AM – 4:00 PM
TTY	711
Write	Community Health Access to Addiction and Mental Healthcare Project (CHAMP)

	Community Health Access to Addiction and Mental Healthcare Project (CHAMP) – Contact Information
	Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017
Email	ombuds@oasas.ny.gov
Website	www.champny.org

	Community Health Advocates (CHA) - Contact Information
Call	1-888-614-5400 Mon.-Fri. 9:00 AM - 4:00 PM
TTY	711
Write	Community Health Advocates (CHA) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017
Email	cha@cssny.org
Website	www.communityhealthadvocates.org

This ombudsman can help enrollees in our Health and Recovery Plan (HARP), and enrollees in our Medicaid Managed Care (MMC) plan that get long term services and supports.

	Independent Consumer Advocacy Network (ICAN) - Contact Information
Call	1-844-614-8800 Mon.-Fri. 9:00 AM - 5:00 PM.
TTY	711
Write	Independent Consumer Advocacy Network (ICAN) Community Service Society of New York 633 Third Ave, 10th Floor New York, NY 10017

	Independent Consumer Advocacy Network (ICAN) - Contact Information
Email	ican@cssny.org
Website	www.icannys.org

SECTION 7 Programs to help people pay for prescription drugs

The Medicare website (www.Medicare.gov/basics/costs/help/drug-costs) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Because you're eligible for Medicaid, you qualify for and get Extra Help from Medicare to pay for your prescription drug plan costs. You don't need to do anything further to get this Extra Help.

If you have questions about Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048;
- The Social Security Office at 1-800-772-1213, between 8 am and 7 pm, Monday through Friday. TTY users call 1-800-325-0778; or
- Your State Medicaid Office at 1-800-541-2831.

If you think you’re paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of your proper copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

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

- A copy of your Medicaid card if it includes your eligibility date during the period of time in question;
- A copy of a letter from the state or SSA showing Medicare Low-Income Subsidy status;
- A copy of a state document that confirms active Medicaid status during the period of time in question;
- A screen print from the state’s Medicaid systems showing Medicaid status during the period of time in question;

- Evidence of recent point-of-sale Medicaid billing and payment in the pharmacy's patient profile, backed up by one of the above indicators after the point-of-sale.

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

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

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

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Customer Service 1-877-269-5706 (TTY users call 711) if you have questions.

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

Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through The AIDS Drug Assistance Program (ADAP).

Note: To be eligible for the ADAP in your State, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call The AIDS Drug Assistance Program (ADAP).

	New York AIDS Drug Assistance Program (ADAP)
Call	1-800-542-2437 8 a.m. - 5 p.m. local time, Monday - Friday
TTY	711 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	HIV Uninsured Care Programs Empire Station P.O. Box 2052 Albany, NY 12220
Website	https://www.health.ny.gov/diseases/aids/general/resources/adap/

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help people pay for prescription drugs based on financial need, age, medical condition, or disabilities. Each state has different rules to provide drug coverage to its members.

In New York, the State Pharmaceutical Assistance Program is New York State Elderly Pharmaceutical Insurance Coverage (EPIC).

	New York State Elderly Pharmaceutical Insurance Coverage (EPIC) – Contact Information
Call	1-800-332-3742 8 a.m. - 5 p.m. local time, Monday - Friday
TTY	1-800-290-9138 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking.
Write	EPIC P.O. Box 15018 Albany, NY 12212-5018
Website	https://www.health.ny.gov/health_care/epic/

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** Extra Help from Medicare and help from your SPAP and ADAP, for those who qualify, is more advantageous than participation in the Medicare Prescription Payment Plan.To learn more about this payment option, call Customer Service at 1-877-269-5706 (TTY users call 711) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
Call	1-833-246-7717 Calls to this number are free. October 1 - December 7: 8:00 AM to 1:00 AM EST, 7 days a week. December 8 - March 31: 8:00 AM to 11:00 PM EST, 7 days a week. April 1 - September 30: 8:00 AM to 11:00 PM EST, Monday through Friday. Customer Service 1-877-269-5706 (TTY users call 711) also has free language interpreter services for non-English speakers.
TTY	711 Calls to this number are free. October 1 - December 7: 8:00 AM to 1:00 AM EST, 7 days a week. December 8 - March 31: 8:00 AM to 11:00 PM EST, 7 days a week. April 1 - September 30: 8:00 AM to 11:00 PM EST, Monday through Friday.
Fax	1-440-557-6525
Write	SimplicityRx MPPP Election Dept. 13900 N. Harvey Ave Edmund, OK 73013
Website	https://activate.rxpayments.com/

SECTION 8 Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions

about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information	
Call	1-877-772-5772 Calls to this number are free. Press “0” to speak with an RRB representative from 9 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9 am to 12 pm on Wednesday. Press “1” to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren’t free.
Website	https://RRB.gov

CHAPTER 3:

Using our plan for your medical and other covered services

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

This chapter explains what you need to know about using our plan to get your medical care and other services covered. For details on what medical care and other services our plan covers, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 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 as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay nothing for covered services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 Basic rules for your medical care and other services to be covered by our plan

As a Medicare and Medicaid health plan, Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) must cover all services covered by Original Medicare and may offer other services in addition to those covered under Original Medicare. Please see the Medical Benefits Chart in Chapter 4.

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** in Chapter 4.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you must choose a network PCP (go to Section 2.2 for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information, go to Section 2.3.
    - You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP, go to Section 2.2.
- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means that you will have to pay the provider in full for services you get. Here are three exceptions:
    - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
    - If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You should obtain authorization from the plan prior to seeking care. In this situation, we'll cover these services at no cost to you. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
    - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area or when your provider for this service is temporarily unavailable or inaccessible. The cost sharing you pay our plan for dialysis can never be higher than the cost sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider that is outside our plan's network, your cost sharing can't be higher than the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost sharing for the dialysis may be higher.

SECTION 2 Use providers in our plan's network to get your medical care and other services

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

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

- When you join our plan, you will 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. If you do not have a PCP at the time you join, a plan representative can help you select one. If you are not able to choose a PCP, we will assign you to a contracted PCP with a convenient office location based on your home address.
- PCPs can be any of the following kinds of doctors as long as they are in our plan's network:
  - General practitioners
  - Family practitioners
  - Internal Medicine doctors
  - Pediatricians
  - Geriatrics
- As we explain below, you can get your routine or basic care from your PCP. Your PCP can also coordinate the rest of the covered services you get as a plan member.
- You will see your PCP for most of your routine health care needs.
- Your PCP may provide most of your care and may help arrange or coordinate the rest of the covered services you get as a plan member. This includes your X-rays, laboratory tests, therapies, care from doctors who are specialists, hospital admissions and follow-up care. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, your PCP can help arrange your care. In some cases, your PCP will need to get prior authorization (prior approval). Since your PCP may provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.
- Your PCP is available to coordinate your care with specialists and other providers. If one of your providers orders a service that requires an authorization, the ordering provider is responsible for obtaining a prior authorization from our plan.
- For in-network services (in our plan): All services must be coordinated by your primary care provider (PCP). You may need an approval from the plan before getting the care. This is called

getting a prior authorization. Ask your provider or call the plan to learn more. If you receive care from a participating specialist without a referral, your claim may not be paid.

How to choose a PCP?

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

To select a new PCP, you may refer to the *Provider/Pharmacy Directory* you received, the *Provider/Pharmacy Directory* on our website, or call the Customer Service phone number on the back cover of this document. 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.

Customer Service also can help you choose a doctor. If you are already seeing a doctor, you can look in the *Provider/Pharmacy Directory* to see if that doctor is in our network. If so, you can tell us you want to keep that doctor.

How to change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP.

If you want to change your PCP, and you need help finding a network provider, please call Customer Service at the number shown on the back cover of this document, or visit our website to access our online, searchable directory. If you would like a *Provider/Pharmacy Directory* mailed to you, you may call Customer Service, or request one on our website.

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

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

Section 2.2 Medical care and other services you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams.
- Flu shots, COVID-19 vaccines, Hepatitis B vaccinations, and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.

- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Customer Service at 1-877-269-5706 (TTY users call 711) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.
- This plan does not require referrals from your PCP or any network providers for the benefits listed above.
- For additional covered services that do not require a referral and/or prior authorization/ approval; see Chapter 4, Medical Benefits Chart.

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. For example:

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

For certain services provided by specialists, either your PCP or specialist will need to get prior approval from us. This is called getting "prior authorization." (For more information about this, see the Medical Benefits Chart in Chapter 4.) When we give our decision, we base it on two things. First there are Medicare's and the state Medicaid program'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 must get our approval before getting care from providers not in our plan unless it's for urgent care, emergency care or renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call Customer Service. If you are referred or feel you need to use a provider who is not in our plan, you must call us to get approval before you get care.

When a specialist or another network provider leaves our plan

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

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
    - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
    - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network at in-network cost sharing. You should obtain authorization from the plan prior to seeking care.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

You must receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. This means you will have to pay the provider in full for the services furnished. There are certain exceptions, listed below.

- Emergency care or urgently needed services from out-of-network providers (see section 2.2 for more information).

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area (see section 2.2 for more information).
- Medical care that is required by Medicare but there are no specialists in our network to provide care. In this situation:
    - The cost-sharing will be the same that you would pay as if you got the care from a network provider
    - Our plan must confirm there is not a network provider available
    - Your PCP or the out-of-network provider performing services must contact the plan and obtain an approved authorization before the services are rendered.
    - If there is not an approved authorization on file your claim will be denied and you will be responsible to pay the provider in full for the services furnished.
- In any situation not described above, out-of-network care will not be covered without your PCP obtaining an authorization from the plan prior to services being rendered.

SECTION 3 How to get services in an emergency, disaster, or urgent need for care

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they're not part of our network.
- **As soon as possible, make sure 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 our plan membership card.

Covered services in 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 giving you emergency care will decide when your condition is stable and when the medical emergency is over.

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

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care *only* if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care.
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

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

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

You can receive care from any urgent care provider included in your *Provider/Pharmacy Directory.* If you are having trouble finding an urgent care provider, please call Customer Service.

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. For more information, see the Medical Benefits Chart in Chapter 4 of this document.

Section 3.3 Get care during a disaster

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

Visit: www.anthem.com for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.4.

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

If you paid for your covered services, or if you get a bill for covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 If services aren't covered by our plan

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan, or you get services out-of-network without authorization, you're responsible for paying the full cost of services. Before paying for the cost of the service, members should check if the service is covered by Medicaid.

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

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it 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 rest. Like for all covered services, you'll pay nothing for the covered services you get in the clinical research study.

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

Section 6.2 How to get care from a religious non-medical health care institution

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

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

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

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

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

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), you usually will acquire ownership of the DME items following a rental period not to exceed 13 months from an in-network provider or 13 months rental from a non-network provider. Your copayments will end when you obtain ownership of the item. Oxygen related equipment rental is 36 months before ownership transfers to you.

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

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

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 don't count. You'll 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 didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) 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 HealthPlus Full Dual Advantage LTSS (HMO D-SNP) or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months, you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

CHAPTER 4:
Medical Benefits Chart (what's covered)

SECTION 1 Understanding covered services

The Medical Benefits Chart lists your covered services as a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). This section also gives information about medical services that aren't covered and explains limits on certain services.

Section 1.1 You pay nothing for your covered services

Because you get help from Medicaid, you pay nothing for your covered services as long as you follow the plans' rules for getting your care. (Go to Chapter 3 for more information about the plans' rules for getting your care.)

Section 1.2 What's the most you'll pay for Medicare Part A and Part B covered medical services?

Note: Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum. You're not responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services.

Medicare Advantage Plans have limits on the amount you have to pay out-of-pocket each year for medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $9,250.00.**

The amounts you pay for copayments and coinsurance for covered services count toward this maximum out-of-pocket amount. The amounts you pay for Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are noted in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $9,250.00, you won't have to pay 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 2 The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) covers (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these requirements are met:

- Your Medicare covered services must be provided according to Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) *must* be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet 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.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered unless it's emergency or urgent care, or unless our plan or a network provider gave you a referral. This means that you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart.
- 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:

- You're covered by both Medicare and Medicaid. Medicare covers health care and prescription drugs. Medicaid covers your cost sharing for Medicare services, including hospital and doctor visits. Medicaid also covers services Medicare doesn't cover, like home and community-based services or other Medicaid-only services.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook.

View it online at www.Medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227) TTY users call 1-877-486-2048.)

- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.
- We provide the plan benefits in the chart below and immediately following that chart, the Medicaid benefits are provided.
- If you're within our plan's 6-month period of deemed continued eligibility, we'll continue to provide all Medicare Advantage plan-covered Medicare benefits. However, during this period, we won't cover Medicaid benefits that are included under the Medicaid state plan. Medicare cost-sharing amounts for Medicare basic and supplemental benefits don't change during this period.

You don't pay anything for the services listed in the Medical Benefits Chart, as long as you meet the coverage requirements described above.

Important Benefit Information for Enrollees with Chronic Conditions

If you're diagnosed with any of the chronic condition(s) listed below and your condition:

1. Is life threatening or significantly limits your overall health or function; AND
2. Has a high risk of hospitalization or other adverse health outcomes; AND
3. Requires intensive care coordination

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

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

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

wheelchair, non-invasive ventilation (NIV), wound vacuums, bipap machines, mechanical in-exsufflation devices, group 2 or group 3 mattresses

Eligible Conditions:

- Chronic alcohol use disorder and other substance use disorders;
- Autoimmune disorders:
  - Polyarteritis nodosa,
  - Polymyalgia rheumatica,
  - Polymyositis,
  - Dermatomyositis
  - Rheumatoid arthritis,
  - Systemic lupus erythematosus,
  - Psoriatic arthritis, and
  - Scleroderma;
- Cancer;
- Cardiovascular disorders:
  - Cardiac arrhythmias,
  - Coronary artery disease,
  - Peripheral vascular disease, and
  - Valvular heart disease;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
  - Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%)
- Overweight, Obesity, and Metabolic Syndrome;
- Chronic gastrointestinal disease:
  - Chronic liver disease,

  - Non-alcoholic fatty liver disease (NAFLD),
  - Hepatitis B,
  - Hepatitis C,
  - Pancreatitis,
  - Irritable bowel syndrome, and
  - Inflammatory bowel disease;
- Chronic kidney disease (CKD):
  - CKD requiring dialysis/End-stage renal disease (ESRD), and
  - CKD not requiring dialysis;
- Severe hematologic disorders:
  - Aplastic anemia,
  - Hemophilia,
  - Immune thrombocytopenic purpura,
  - Myelodysplastic syndrome,
  - Sickle-cell disease (excluding sickle-cell trait), and
  - Chronic venous thromboembolic disorder;
- HIV/AIDS;
- Chronic lung disorders:
  - Asthma,
  - Chronic bronchitis,
  - Cystic Fibrosis,
  - Emphysema,
  - Pulmonary fibrosis,
  - Pulmonary hypertension, and
  - Chronic Obstructive Pulmonary Disease (COPD);
- Chronic and disabling mental health conditions:
  - Bipolar disorders,

  - Major depressive disorders,
  - Paranoid disorder,
  - Schizophrenia,
  - Schizoaffective disorder,
  - Post-traumatic stress disorder (PTSD),
  - Eating Disorders, and
  - Anxiety disorders;
- Neurologic disorders:
  - Amyotrophic lateral sclerosis (ALS),
  - Cerebral Palsy
  - Epilepsy,
  - Extensive paralysis (that is, hemiplegia, quadriplegia, paraplegia, monoplegia),
  - Huntington's disease,
  - Multiple sclerosis,
  - Parkinson's disease,
  - Polyneuropathy,
  - Fibromyalgia,
  - Chronic fatigue syndrome,
  - Spinal cord injuries,
  - Spinal stenosis,
  - Stroke-related neurologic deficit; and
  - Traumatic brain injury
- Stroke;
- Post-organ transplantation care;
- Immunodeficiency and Immunosuppressive disorders;
- Conditions that may cause cognitive impairment:
  - Alzheimer's disease,

  - Intellectual and developmental disabilities,
  - Traumatic brain injuries,
  - Disabling mental illness associated with cognitive impairment, and
  - Mild cognitive impairment;
- Conditions that may cause similar functional challenges and require similar services:
  - Spinal cord injuries,
  - Paralysis,
  - Limb loss,
  - Stroke, and
  - Arthritis;
- Chronic conditions that impair vision, hearing (deafness), taste, touch, and smell;
- Conditions that require continued therapy services in order for individuals to maintain or retain functioning.
- Other
  - Chronic hypertension
  - Osteoporosis
  - Chronic back pain

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

For more detail, go to the Special Supplemental Benefits for the Chronically Ill row in the Medical Benefits Chart below. Contact us to find out exactly which benefits you may be eligible for.

 This apple shows the preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Additional services may be covered in accordance with your Medicaid benefits and guidelines.

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture This plan covers supplemental acupuncture, which is an alternative method to treat illness or pain. Your treatment plan may require verification of medical necessity. 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 per visit. This plan offers coverage for 24 visits every year.
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions will be covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.	**In-network:** **$0.00** copay for each Medicare-covered acupuncture visit.

Covered Service	What you pay
Provider Requirements: Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e. Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by our regulations at 42 CFR §§ 410.26 and 410.27. 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 if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	**$0.00** copay for each covered, one-way ambulance trip by ground or water. **$0.00** copay for each covered, one-way air ambulance trip.

Covered Service	What you pay
Prior authorization may be required.	
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.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**In-network:** There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women aged 40 and older • Clinical breast exams once every 24 months	**In-network:** There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**In-network:** **$0.00** copay for each covered therapy visit to treat you if you've had a heart condition.

Covered Service	What you pay
Prior authorization may be required.	
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.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	**In-network:** There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 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're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 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.
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation Additional covered supplemental chiropractic benefits include: • 12 visits each year for routine chiropractic services. Your treatment plan may require verification of medical necessity.	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 Medicare-covered visit to see a chiropractor.

Covered Service	What you pay
Prior authorization may be required.	**$0.00** copay for routine chiropractic visits.
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning. Prior authorization may be required.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. **In-network:** **$0.00** copay for each covered Primary Care Provider (PCP) office visit for Chronic pain management and treatment services. **$0.00** copay for each covered specialist office visit for Chronic pain management and treatment 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 aren't at high-risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal	**In-network:** There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and subject to copayment/coinsurance. **$0.00** copay for a biopsy or removal of tissue during a screening exam of the colon.

Covered Service	What you pay
cancer, coverage may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high-risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every 3 years. • 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. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Dental services - Medicare-covered In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams	**In-network:** For in-network Medicare-covered dental benefits, you must use a provider that is part of the Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) medical network. You can find these providers in the

Covered Service	What you pay
prior to organ transplantation. Prior authorization and referral may be required.	Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$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: 1 Restorative Services including Amalgam or resin-based restorations (fillings) every 24 months, per tooth, per surface, 1 Crown covered every 60 months per tooth, 1 Endodontic services per lifetime, per tooth, 1 Periodontics or periodontal root planing and scaling every 24 months, per site/quad, 4 Surgical Extractions or routine removal of tooth/teeth in 12 months . This plan also covers Removable Prosthodontic Services or full and/or partial dentures when they are determined to be medically necessary, including when necessary to alleviate a serious health condition or one that is determined to affect employability. IMPT Note: Require prior authorization for most of these dental services. Any amount not used at the end of the plan year will expire. Our dental allowance can be used toward approved dental services: **Diagnostic and Preventive Services:** • Exams • X-rays • Cleanings	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** In-network dental services are covered. To be covered in-network, dental services must be performed by a provider that is contracted with our approved dental vendor to provide supplemental dental services. When using an in-network provider, you pay: • **$0.00** copay for covered preventive dental services designed to help prevent disease. • **$0.00** copay for covered comprehensive dental services.

Covered Service	What you pay
• Other preventive services (treatment to stop tooth decay progression) • Other diagnostic services (specialized X-rays) **Comprehensive Dental Services:** • Restorative (fillings and crowns) • Endodontics (root canals, pulp & root therapy, and other related services) • Periodontics (deep cleaning services and other gum-related treatments) • Fixed Prosthodontics (bridges) • Removable Prosthodontics (complete or partial dentures services) • Oral and Maxillofacial Surgery (teeth extractions, surgical repairs, and other related specialized procedures) • Adjunctive General Services (emergency treatment, sedation, anesthesia, night guards) • Maxillofacial Prosthetic Services • Implant Services (single implants and related services) **Please note:** • Prior authorization is required for cone beam services and most comprehensive services prior to treatment being performed. Services must meet our clinical criteria and guidelines to be approved and covered. • Other dental services are subject to limitations. For detailed information on prior authorization, limitations, and exclusions, please refer to the supplemental dental section immediately following this Medical Benefits Chart.	**Out-of-network:** Out-of-network dental services are NOT covered. Dental services performed by a provider that is not contracted with our approved dental vendor are considered out-of-network. When using an out-of-network provider, you pay: • **100%** of all the cost of dental services Talk to your provider and confirm all coverage, costs, and codes prior to services being performed. For more information or to find a provider, call the Dental Member Services number located on the back of your member ID card. Additional services may be covered in accordance with your Medicaid benefits and guidelines. Services beyond Medicare limitations and exclusions would be evaluated under Medicaid.

Covered Service	What you pay
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	**In-network:** There is no coinsurance, copayment, or deductible for an annual depression screening visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.
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 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	**In-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 for training to help you learn how to monitor your diabetes.

Covered Service	What you pay
This plan covers one blood glucose monitor every calendar year. Freestyle and Accu-Chek® 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. This plan covers only Freestyle (made by Abbott) and Accu-Chek® (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. If you purchase these supplies through a Durable Medical Equipment (DME) provider, these items will NOT be covered. Lancets may be purchased at either a network retail pharmacy or our mail order pharmacy. However, lancets are limited to the following manufacturers: Freestyle, Trividia, Accu-Chek®, HTL-Strefa, 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	

Covered Service	What you pay
for test strips or lancets greater than the amount listed above or are not from the approved manufacturers.	
Durable medical equipment (DME) and related supplies (For a definition of Durable Medical Equipment, go to Chapter 12 and Chapter 3.) Covered items include, but aren't 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 doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.anthem.com. 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. Continuous Glucose Monitors are available as a covered benefit for diabetics who require the use of insulin and have difficulty controlling their blood sugar levels. This plan only covers FreeStyle Libre® (made by Abbott) and Dexcom Continuous Glucose Monitors (CGMs). We will not cover other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider, these items will not be covered.	**In-network:** Durable medical equipment (DME): **$0.00** copay Medicare oxygen equipment: **$0.00** copay every billing cycle (rental period) Your cost sharing will not change after being enrolled for 36 months. If prior to enrolling in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) you had made 36 months of rental payments for oxygen equipment coverage, your cost sharing in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) is **$0.00** copay every billing cycle (rental period). **$0.00** copay for CGMs and related supplies.

Covered Service	What you pay
Coverage limitations: • 2-3 Sensors per month depending on the receiver • One receiver every 2 years Insulin pumps are different than a CGM and can be purchased through a DME provider. 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. 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. You must get durable medical equipment through our approved suppliers. You cannot purchase these items from a pharmacy. Prior authorization may be required.	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman,	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for each emergency room visit. If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your

Covered Service	What you pay
loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. Emergency care coverage is worldwide. 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, seven days a week, 365 days a year.	inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost sharing you would pay at a network hospital. **$0.00** copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit.
Everyday Options Allowance This benefit provides a combined spending allowance of **$300** each month on your Benefits Mastercard® Prepaid Card. This spending allowance can be used to pay for: • Assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more • OTC products like vitamins, first aid supplies, pain-relievers, and more	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 Everyday Options Allowance.

Covered Service	What you pay
If you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), you may qualify for: • Healthy Foods like fresh meats, seafood, fruits, vegetables, dairy products, pantry staples, and more • Utilities including gas for your home, electric, water, cable, internet, or cell phone services The Benefits Prepaid Card is automatically loaded at the beginning of each month. Unused amounts expire at the end of each month. The card cannot be used to set up automated recurring transactions. You have a variety of convenient ways to use your benefit: • Shop in-store at participating retailers near you (OTC and Healthy Foods only) • Shop online on the approved vendor website • Shop on the approved vendor mobile app • Call to place an order • Order by mail (Assistive Devices and OTC only) • With your utility provider **Note:** • Upon enrollment, you will receive a mailer: ○ Including further detail on how to use your benefits and your Benefits Prepaid Card ○ Outlining products available for purchase (OTC and Assistive Devices only) • Orders for OTC products and Healthy Foods must be placed through the plan's approved vendor or purchased at a participating retail store. Specific name brands may not be available and quantities may be limited or restricted. Minimum order quantities and delivery fees may apply for	

Covered Service	What you pay
online/delivery orders. Not all products are available for delivery. See ordering site for details. • Assistive devices are limited to those offered by the approved vendor and subject to availability. Quantity limits may apply. Installation services are not included. Any repair or replacement is limited to the manufacturer's warranty. • Once you reach your monthly spending allowance, you are responsible for the remaining cost of your purchases. • You may not use this card to purchase items such as gift cards, tobacco or alcohol. • You can only pay for your own items or services and cannot convert the card to cash. • Some utility providers/merchants may charge processing fees for online or credit card payments. 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.	
Health and wellness education programs These programs are designed to enrich the health and lifestyles of members. • 24/7 Nurseline: As a member, you have access to a 24-hour nurse line, 7 days a week, 365 days a year. - see 24/7 Nurseline for more details • SilverSneakers® Fitness Program - see SilverSneakers® for more details	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 health and wellness programs covered by this plan.

Covered Service	What you pay
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. 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 with the process to 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 an approved vendor acting on our behalf, may need to contact you using the phone number you provided to confirm shipping details and any nutritional requirements. A portion of this benefit may be used to obtain meal replacement shakes.	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 up to 2 meals a day for 21 days following your discharge from the hospital or skilled nursing facility (SNF).
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 you get them from 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 HealthPlus Full Dual Advantage LTSS (HMO D-SNP) medical network. You can find them in the Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for each covered hearing evaluation to determine if you need medical treatment for a hearing condition.
Hearing services - Supplemental	Any costs you pay for Medicare Non-covered Services will not

Covered Service	What you pay
This plan provides additional hearing coverage not covered by Original Medicare. This plan covers 1 routine hearing exam every year. **$300** maximum plan benefit for over-the-counter hearing aids OR 1 routine hearing aid fitting evaluation and a **$4,000** maximum plan benefit for prescribed hearing aids every year. Limit up to one pair of hearing aid(s) per year, regardless of type. Over-the-Counter (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 vendor to give you the most options. For your hearing aid to be covered, you must select a device from the covered list available through our approved vendor. Hearing aids obtained through an unauthorized vendor are not covered. The approved vendor will send your prescription hearing aids directly to your audiologist and OTC hearing aids directly to you. Prescribed hearing aids may require prior authorization from our hearing vendor to ensure you are fitted with the most appropriate device available under the plan. If you 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 OTC hearing aids. After plan paid benefits for routine hearing exams or hearing aids, you are responsible for the remaining cost. Prior authorization may be required.	count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay for routine hearing exam(s). **$0.00** copay for hearing aids up to the maximum plan benefit amount. Hearing aids are limited to specific devices based on your hearing needs.
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months If you are pregnant, we cover: • Up to 3 screening exams during a pregnancy	**In-network:** There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to	**In-network:** **$0.00** copay for each covered

Covered Service	What you pay
be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but aren't limited to: • 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.	visit from a home health agency.
Home infusion therapy Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • 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:	**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): **$0.00** copay - includes the external infusion pump and the related supplies by a contracted DME Provider. **$0.00** copay for the infusion drug(s). You may pay less for certain rebatable drugs. This list and the cost of each rebatable drug changes every quarter.

Covered Service	What you pay
• 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 Prior authorization may be required.	
Hospice care You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including program we own, control, or have 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're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan you must continue to pay plan premiums. **For hospice services and for services that are covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services that are covered by Medicare Part A or B and are**	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. **$0.00** copay if you get a hospice consultation by a specialist before you elect hospice.

Covered Service	What you pay
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 aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow the plan rules (like if there's a requirement to get prior authorization) • If you get the covered services from a network provider and follow plan rules for getting services, you pay our plan cost-sharing amount for in-network services • If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare **For services that are covered by our plan but not covered by Medicare Part A or B:** The plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit**: If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), 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. Prior authorization may be required.	

Covered Service	What you pay
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B • COVID-19 vaccines • Other vaccines if you're at risk and they meet Medicare Part B coverage rules We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 8 for more information. You can get a flu/influenza, pneumonia, or COVID-19 vaccines without asking a doctor to refer you.	**In-network:** There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. The shingles shot is only covered under the Part D drug benefit. The amount you pay for the shot will depend on the Part D drug benefits found in Chapter 6. The shingles shot is not covered under the Part B drug benefit.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. Additional services may be covered in accordance with your Medicaid benefits and guidelines; however, this plan covers the Medicare limit of 90 days per benefit period and 60 extra Lifetime Reserve days over your lifetime. Covered services include but aren't limited to: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units)	**In-network:** **$0.00** copay per stay A benefit period starts on the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't had any inpatient hospital care or skilled care in a SNF for 60 days in a row. This plan covers 90 days each benefit period. This plan pays for 60 extra days over your lifetime. You have no copay for these extra days. The hospital should tell the plan within one business day of any emergency admission. If you get authorized inpatient

Covered Service	What you pay
• Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If the plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient	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.

Covered Service	What you pay
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 starts 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're not sure if you are an inpatient or an outpatient, you should ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.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. Prior authorization may be required.	

Covered Service	What you pay
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. Prior authorization may be required. 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:** **$0.00** copay for each covered hospital stay.
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay This plan covers 90 days per benefit period and 60 extra lifetime reserve days over your lifetime for inpatient days and up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached this coverage limit, the plan will no longer cover your stay in the SNF. However, in some cases, we will cover certain services you receive while you are in the SNF. If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or the skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • 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	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.

Covered Service	What you pay
• 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 the first year you get 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 get 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 members eligible for Medicare-covered medical nutrition therapy services.
Medicare Community Resource Support Do you need help with a specific issue? While your plan includes Medicare benefits along with the extra benefits outlined in this chart, you may sometimes require more support. As a member, you have access to our Medicare Community Resource Support team. They are here to help you find community-based services and support programs in your area. To use this benefit, call Customer Service at the number on your member ID card and ask for the Medicare Community Resource Support team.	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 the assistance provided by the Medicare Community Resource Support team.
Medicare Diabetes Prevention Program (MDPP) **MDPP services are covered for eligible people under all Medicare health plans.**	**In-network:** There is no coinsurance,

Covered Service	What you pay
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.	copayment, or deductible for the MDPP benefit.
Medicare Part B drugs **These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:** • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan • The Alzheimer's drug, Leqembi®, (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia • Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug	**In-network:** **$0.00** copay for a one-month's supply of Medicare-covered Part B Insulin Drugs. **$0.00** copay for chemotherapy and other drugs covered by Medicare Part B.

Covered Service	What you pay
• Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar® • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, and topical anesthetics • Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, Darbepoetin Alfa®, Mircera®, or Methoxy polyethylene glycol-epoetin beta) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	

Covered Service	What you pay
• Parenteral and enteral nutrition (intravenous and tube feeding) Some of the Part B covered drugs listed above may be subject to step therapy. To access the Part B Step Therapy list, go to https://shop.anthem.com/medicare, enter your ZIP code, and select Plan Documents. Then click Prescription Drug Coverage Details and choose Part B Step Therapy from the list. We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. 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. Prior authorization may be required for chemotherapy and all other Part B drugs. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D drugs through our plan is explained in Chapter 6.	
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 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.	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 the 24/7 Nurseline.

Covered Service	What you pay
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.
Opioid treatment program services Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA)-approved opioid agonist and antagonist medication-assisted treatment (MAT) medications • Dispensing and administration of MAT medications (if applicable) • Substance use counseling • Individual and group therapy • Toxicology testing • Intake activities • Periodic assessments Prior authorization may be required.	**In-network:** **$0.00** copay for Opioid Treatment Program Services.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings	**In-network:** **$0.00** copay for each covered lab service. **$0.00** copay for hemoglobin A1c or urine tests to check albumin levels. **$0.00** copay for each covered diagnostic procedure or test.

Covered Service	What you pay
• 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. • Diagnostic non-laboratory tests such as CT scans, MRIs, EKGs, and PET scans when your doctor or other health care provider orders them to treat a medical problem. • Other outpatient diagnostic tests 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. Prior authorization may be required.	**$0.00** copay for tests to confirm chronic obstructive pulmonary disease (COPD). **$0.00** copay for each covered radiation therapy service. **$0.00** copay for each covered X-rays. **$0.00** copay for each covered diagnostic radiology service. **$0.00** copay for covered ultrasounds in a provider's office or freestanding radiology center. **$0.00** copay for covered ultrasounds in the outpatient department of a network hospital or facility. **$0.00** copay for blood, blood storage, processing and handling services. **$0.00** copay for surgery bandages and supplies, such as casts and splints.
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.	**In-network:** **$0.00** copay for observation room service you get at an outpatient hospital.

Covered Service	What you pay
For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at www.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. Prior authorization may be required.	
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 aren't 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 • Medical supplies such as splints and casts • Certain drugs and biologicals you can't give yourself	**In-network:** **$0.00** copay for outpatient hospital services such as: • Covered surgery services • Covered observation room services • Medical supplies such as splints and casts **$0.00** copay for partial hospitalization for mental health or substance abuse. Additional information about other outpatient services can be found elsewhere in this benefit chart for emergency room visits, outpatient

Covered Service	What you pay
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Prior authorization may be required.	diagnostic tests and therapeutic services, and laboratory tests. Please see the Medicare Part B drugs section for details on certain drugs and biologicals. 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:** **$0.00** copay 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:** **$0.00** copay for each covered physical and speech therapy visit. **$0.00** copay for each covered occupational therapy visit.
Outpatient substance use disorder services Outpatient and ambulatory substance use disorder services/treatment is supervised by an appropriate licensed professional. Outpatient treatment is provided for individuals or groups, and family therapy may be an additional component.	**In-network:** **$0.00** copay for each covered therapy visit. This applies to individual or group therapy.

Covered Service	What you pay
Additional services may be covered in lieu of hospitalization, or as a step-down after hospitalization for substance use-related conditions. Prior authorization may be required.	
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient. Prior authorization may be required.	**In-network:** **$0.00** copay for each covered surgery in an ambulatory surgical center. **$0.00** 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.
Partial hospitalization services and Intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than care you get in your doctor's, therapist's licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization. *Intensive outpatient service* is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that is more intense than care you get 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.	**In-network:** **$0.00** copay for each covered partial hospitalization visit or intensive outpatient service.

Covered Service	What you pay
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.	
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • 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-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	**In-network:** **$0.00** copay for each covered Primary Care Provider (PCP) office visit. **$0.00** copay for each covered specialist office visit. **$0.00** copay for each Medicare-covered hearing exam to diagnose a hearing condition. **$0.00** copay for other health care professionals including midwives, physician assistants, nurse practitioners, and OB/GYNs. **$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 defined Medicare-covered telehealth services from your primary care physician, a nurse practitioner or physician's assistant affiliated with network primary care, a network mental health provider or network psychiatric provider.

Covered Service	What you pay
• Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders, if: ○ You have an in-person visit within 6 months prior to your first telehealth visit ○ You have an in-person visit every 12 months while getting these telehealth services ○ Exceptions can be made to the above for certain circumstances • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers • Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if:** ○ You're not a new patient **and** ○ The check-in isn't related to an office visit in the past 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 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**	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.

Covered Service	What you pay
○ 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 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:** **$0.00** 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 medical conditions affecting the lower limbs.
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 • 6 routine foot care visit(s) each year.	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 routine foot care visit.

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	**In-network:** There is no coinsurance, copayment, or deductible for the PrEP benefit.
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.
Prosthetic and orthotic devices and related supplies Devices (other than dental) that replace all or part of a body part or function. These include, but aren't limited to: testing, fitting, or training in the use of prosthetic and orthotic devices as well as colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to *Vision Care* later in this table for more detail.	**In-network:** **$0.00** copay for 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.

Covered Service	What you pay
Prior authorization may be required.	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.
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:** **$0.00** copay for each covered pulmonary rehabilitation visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 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.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.
Screening for Hepatitis C Virus Infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965. If you were born between 1945-1965 and aren't considered high risk, we cover a screening once. If you're at high risk (for example,	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

Covered Service	What you pay
you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
Screening for lung cancer with low dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. **Eligible members are** people age 50 - 77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. *For LDCT lung cancer screenings after the initial LDCT screening:* the member must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare covered 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. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

Covered Service	What you pay
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 6 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're 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 drugs** in this table. 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: • 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 • Each training session to learn how to care for yourself if you need dialysis **$0.00** copay for each covered kidney disease education service visit. 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 online and at participating locations.[1] You have access to a nationwide network of participating locations where you can take classes[2] and use exercise equipment and other amenities. Enroll in as many	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:**

Covered Service	What you pay
locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active outside of traditional gyms at recreation centers, parks, and other neighborhood locations. SilverSneakers also connects you to a support network and online resources through SilverSneakers LIVE classes, SilverSneakers On-Demand videos, and the SilverSneakers GO mobile app. All you need to get started is your personal SilverSneakers ID number. Go to SilverSneakers.com to learn more about your benefit or call 1-855-741-4985 (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. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	**$0.00** copay for the SilverSneakers® Fitness Program.
Skilled nursing facility (SNF) care (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) 100 days per benefit period. No prior hospital stay required. Covered services include but aren't limited to: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services	**In-network:** **$0.00** copay per stay for each skilled nursing facility stay. A benefit period starts on the first day you are an inpatient in a hospital or skilled nursing facility. It ends when you have not had care as an inpatient in a hospital or skilled nursing facility for 60 days in a row. If you go into a skilled nursing facility after one benefit period

Covered Service	What you pay
• Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are also covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to get your care from 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.	has ended, a new benefit period begins. There is no limit on how many benefit periods you can have. 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 benefits are based on the date of admission. If you are admitted in 2026 and are discharged in 2027, the 2026 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.

Covered Service	What you pay
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco regardless of whether they exhibit signs or symptoms of tobacco-related disease • Are competent and alert during counseling • A qualified physician or other Medicare-recognized practitioner provides counseling We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	**In-network:** There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.
Special Supplemental Benefits for the Chronically Ill The following benefit(s) are Special Supplemental Benefits for the Chronically Ill and available to all members who meet the CMS criteria in section 2.1 of this chapter. **Everyday Options Allowance:** The following benefits are part of the Everyday Options Allowance. • Healthy Foods* • Utilities*	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 Special Supplemental Benefits for the Chronically Ill. *Please refer to the Everyday Options Allowance section in this chart for more information.
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:	**In-network:** **$0.00** copay for each covered SET session.

Covered Service	What you pay
• 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.	
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-approved health-related services. Trips may be covered for getting to and from plan-approved medical-related visits, SilverSneakers® locations, and visits to a pharmacy to pick up prescriptions. You can use this benefit for one-way trips or you can schedule a round trip by using two one-way trips. Short stops at a pharmacy to pick up a prescription after a plan-approved medical-related visit can be made as part of the return trip and will not require a separate trip. Ask the provider/facility to call in the prescription so you have a shorter wait. 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	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **In-network:** **$0.00** copay. This plan offers coverage for 60, one-way, routine transportation services every year. Trips are limited to 60 miles.

Covered Service	What you pay
• Rideshare • Wheelchair Van • Public Transportation You must use the plan-approved vendor and schedule trips at least 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.	
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits, (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our 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. 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.	Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. **$0.00** copay for each covered urgently needed service. **$0.00** copay for each covered worldwide urgently needed service.

Covered Service	What you pay
Video Doctor Visits LiveHealth Online lets you see board-certified doctors and licensed therapists, psychologists, and psychiatrists through live, two-way video on your smartphone, tablet, or computer. It's easy to get started! You can sign up at livehealthonline.com or download the free LiveHealth Online mobile app and register. Make sure you have your health plan ID card ready – you'll need it to answer some questions. **Sign up for Free:** • You must enter your health insurance information during enrollment, so have your ID card ready when you sign up. Benefits of a video doctor visit: • 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	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 video doctor visits using LiveHealth Online.

Covered Service	What you pay
and state regulations (rules). [2]Appointments are typically scheduled within seven days but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. [3]Appointments are typically scheduled within 28 days but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	
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 for glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older and Hispanic Americans who are 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 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery. Prior authorization may be required.	**In-network:** For in-network Medicare-covered vision care, you must use a provider in the Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) specialty medical network. You can find them in the Provider/Pharmacy Directory. To learn more, call the Customer Service number on the back cover of this document. **$0.00** copay for the glaucoma screening for people who are at high risk of glaucoma. **$0.00** copay for Medicare-covered diabetic retinopathy and remote imaging for detection of retinal disease (e.g. retinopathy in a patient with diabetes). **$0.00** copay for each Medicare-covered exam to treat an eye condition and comprehensive

Covered Service	What you pay
	ophthalmological exam and evaluation of a patient for retinal disease. After you have covered 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 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. 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.
Vision care - Supplemental The plan provides additional vision coverage not covered by Original Medicare. This plan covers 1 routine eye exam(s) every year. This plan covers up to **$375** for eyeglasses or contact lenses every year.	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 one routine eye exam every plan year. Refractions are covered as part of a routine eye exam and are not covered if billed separately.

Covered Service	What you pay
	$0.00 copay for eyewear up to the allowance amount every plan year. 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 any other in-store discounts.
Welcome to Medicare preventive visit Our 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 preventive services you need (including certain screenings and shots, (or vaccines)), and referrals for other care if needed. **Important:** We cover the *Welcome to Medicare* preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your *Welcome to Medicare* preventive visit.	**In-network:** There is no coinsurance, copayment, or deductible for the *Welcome to Medicare* preventive visit.

Dental services – Supplemental limitations and exclusions

Our plan partners with Liberty Dental to provide your dental benefits.

Please note: Many services require prior authorization through clinical review before treatment is performed to determine if services are appropriate, meet industry standards and New York State Medicaid standards, as well as 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/anthem/Index. 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:

Examinations - You are covered for:

- 2 periodic oral exams every 6 months,
- 2 limited oral exams every 12 months, and
- 1 comprehensive exam per provider per lifetime.

Preventive Services & Prophylaxes (Cleanings) - You are covered for:

- 1 prophylaxis every 6 months (either D1110 or D4910).
- Interim caries arresting medicaments (D1354) are covered 2 times per tooth within a 12-month period, no more than four times per lifetime of the tooth following state criteria (moderate to high caries risk required)
- Tobacco counseling is covered 2 times every 12 months.
- Occlusal Guards are covered.

Please note: Fluoride and Fluoride varnish are NOT covered.

X-Rays - You are covered for:

- Bitewing X-rays 3 times every 12 months,
- Up to 6 periapical radiographs (X-rays) every 6 months (as allowance = 3 (D0220) every 6 months and 6 (D0230) every 12 months, or 1 panoramic or 1 complete series of X-rays once every 36 months (3 years) if clinically indicated and 1 additional (D0330) every 36 months even if one has been taken within three years, to render the necessary dental care when the panorex provided from the referring dentist in not diagnostic or cannot be obtained.
- Cone beam CT and other radiographic images are only covered when clinically indicated and require prior authorization.
    - To be considered for approval, there needs to be significant risk for a complication such as nerve injury or jaw fracture, as well as pathology or trauma.

Please note: Individual periapical X-rays performed on the same day as a full mouth series are NOT covered. Duplication of X-rays are also NOT covered.

Tests and Lab Examinations - You are covered for:

- Biopsy and examination of the oral tissue with prior authorization.
    - Requires documentation that there is a suspicious lesion in the mouth that needs evaluation and the sampling of oral tissue.
- Sialography 2 times per week, and
- TMJ arthrogram including injections 2 times per lifetime.

Please note: You are NOT covered for tomographic survey, bacteriological studies, caries susceptibility, or pulp vitality tests.

Palliative Services - You are covered for:

- 2 palliative emergency services every 12 months, not reimbursable in addition to other therapeutic services performed at the same visit or with an initial or periodic oral exam.

Restorations - You are covered for:

- Amalgam or resin-based restorations (fillings) 1 time every 24 months, per tooth, per surface.
- Resin-based composite crowns, 1 time every 24 months, per tooth.

Crown Services - You are covered for crowns when medically necessary. Prior authorization is required.

- Crowns are covered 1 time every 60 months per tooth.
- Prefabricated crowns made of stainless steel or stainless steel with resin window are covered 1 time every 24 months per tooth.
- Post and core in addition to crown, indirectly fabricated and prefabricated post and core in addition to crown are both covered 1 time every 60 months per tooth.

Please note: Crowns will be covered when medically necessary and require prior authorization.

- Factors that are considered in determining if the crown is medically necessary include:
    - The tooth must have a favorable prognosis and is not routinely restorable with a filling,
    - The crown is not indicated as the result of normal wear and attrition or recession, and
    - The overall status of the dentition is favorable.
- 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.
- The replacement of existing crowns is not covered if they are deemed satisfactory upon clinical review or can be fixed to a satisfactory condition.

- Crowns for the purposes of esthetics, or due to normal wear & attrition, recession, abfraction and/or abrasion are not covered.

Endodontics - You are covered for root canal therapy when medically necessary. Prior authorization and referral is required.

- You are covered for anterior, premolar, and molar teeth 1 time per lifetime, per tooth.
- Retreatment of previous root canal therapy is allowed 1 time per lifetime per tooth.
- Apicoectomy for each additional root and retrograde filling per root is allowed 1 per lifetime per tooth.

Please note: Root canal therapy will be covered when medically necessary and require prior authorization.

- Root canal therapy for members under the age of 21 will be covered when medically necessary. In determining whether a requested root canal is medically necessary, the following factors may be considered:
    - The periodontal status, member compliance, and overall status and prognosis of the tooth is favorable.
- Root canal therapy for members 21 years of age and over will be covered when medically necessary. In determining whether requested endodontic treatment is medically necessary, the following factors may be considered:
    - The tooth must not be able to be removed from your mouth due to a medical condition.
    - The tooth is absolutely needed to hold a bridge or a denture.
    - If the tooth is a back tooth, the following additional factors may be considered:
        - The periodontal status and prognosis of the tooth and overall status of your mouth is favorable.
        - You must also have at least four upper teeth that touch four bottom teeth in the back of your mouth.
        - If the back tooth is a molar, treatment of the tooth is necessary to maintain your bite.
        - The tooth that is having the root canal must touch the teeth on the opposing arch of the mouth when you chew or bite. If the tooth does not touch another tooth, it must hold a denture or a bridge.
    - If the tooth is an anterior tooth, the following additional factors may be considered:
        - The periodontal status and prognosis of the tooth and overall status of your mouth is favorable.

Periodontics – Referral is required. You are covered for:

- Periodontics, or the treatment of diseases of the gums, including subgingival scaling, medication, and curettage, with prior authorization as medically necessary.
- Gingivectomy of gingivoplasty is allowed 1 time every 12 months per quad.
    - D4210 and D4211 are covered only for the correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances, or congenital defects.
- Clinical crown lengthening is allowed 1 time per tooth per lifetime.
    - The periodontal status and prognosis of the tooth and overall status of your mouth is favorable.
    - Crown lengthening is covered only when associated with medically necessary crown or root canal procedure.
- Periodontal scaling and root planing is allowed 1 time every 24 months, per site/quad.
    - For periodontal scaling and root planing (D4341 and D4342) to be considered, there needs to be bone loss around the teeth in that area of the mouth, periodontal pockets, and calculus on your teeth that you can see on your x-ray.
    - Treatment per quadrant is limited to once every two (2) years.
    - Reimbursement for D4341 and/or D4342 is limited to no more than two quadrants on a single date of service.
- Periodontal maintenance (D4910) is covered 1 time every 6 months for members who have previously been treated for periodontal disease with procedures such as scaling and root planing (D4341 or D4342).

Removable Prosthodontic Services - You are covered for dentures when medically necessary. Prior authorization is required.

- You are covered for full and/or partial dentures to alleviate a serious health condition or one that is determined to affect employability.
- Requests for partial dentures will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.
- Complete and/or partial dentures will be approved only when the existing prosthesis is not serviceable or cannot be relined or rebased.
- Reline or rebase of an existing prosthesis will not be reimbursed when such procedures are performed in addition to a new prosthesis for the same arch within 6 months of the delivery of a new prosthesis.

- Dentures, whether unserviceable, lost, stolen, or broken, will not be replaced for a minimum of 8 years (96 months) from initial placement, except when determined to be medically necessary, and require prior authorization with documentation and a form from your dentist.

Please note: The following services do not require prior authorization if they meet the requirements outlined below:

  - Adjustments are covered 4 times every 12 months, per arch, but are not covered within 6 months of placement.
  - Repairs to broken complete or partial denture base is covered 2 times every 12 months, per arch.
  - Repair of missing or broken teeth on a complete denture is covered 2 times every 12 months per arch.
  - Adjustment of complete or partial dentures are covered 4 times every 12 months per arch, but not covered within 6 months of initial placement.
  - Repair resin partial denture base is covered 1 time every 12 months per arch.
  - Repair cast partial framework is covered 1 time every 12 months per arch.
  - Repair or replace broken retentive clasping materials per tooth is covered 2 times every 12 months, per tooth.
  - Replace broken tooth, per tooth is covered 1 time every 12 months, per tooth.
  - Add a tooth or clasp to an existing partial denture is covered 1 time every 12 months, per tooth.
  - Rebase complete denture is covered 1 time every 60 months per arch, but is not payable within 6 months of original seat date,
  - Reline of complete or partial dentures is covered 1 time every 12 months, per arch, but is not payable within 6 months of original seat date.
  - Tissue conditioning is covered 1 time every 60 months, per arch. Once per denture prior to reline, rebase, or impression for new denture. Not payable within 6 months prior to the delivery of a new prosthesis.

Implant Services - You are covered for implants when medically necessary. Prior authorization is required.

- Dental implants, including single implants, and implant related services coverage is included in your plan.

Please note: Implant services will be covered when medically necessary and require prior authorization.

- Prior approval requests for implants must have supporting documentation from the patient's dentist.
- The patient's dental office must submit a completed Evaluation of the Dental Implant Patient Form documenting, among other things, the patient's medical history, current medical conditions being treated, list of all medications currently being taken by the patient, explaining why implants are medically necessary and why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition, and certifying that the patient is an appropriate candidate for implant placement.
- If the patient's dentist indicates that the patient is currently being treated for a serious medical condition, the plan may request further documentation from the patient's treating physician.
- Implant Benefit General Guidelines:
    - The dentist's explanation as to why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition will be reviewed based on the presence/absence of eight (8) points of natural or prosthetic posterior occlusal contact and/or one (1) missing maxillary anterior or two (2) missing mandibular anterior teeth.
    - A complete treatment plan addressing all phases of care is required and should include the following:
        1. Accurate pre-treatment charting;
        2. Complete treatment plan addressing all areas of pathology;
        3. Inter-arch distances;
        4. Number, type and location of implants to be placed;
        5. Design and type of planned restoration(s);
        6. Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.
    - If bone graft augmentation is needed, there must be a 4 to 6-month healing period before a dental implant can be placed.
    - Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
    - Treatment on an existing implant / implant prosthetic will be evaluated on a case- by-case basis.
    - Implant and implant related codes not listed will be considered on a case-by-case basis.

- Documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standard of care.
- For procedure codes D6010 and D6013 the following must be submitted:
  1. Full mouth radiographs or a diagnostic panoramic radiograph including periapicals of site requesting dental implant(s).

- Specific Implant and related service limitations are as follows once meeting the medical necessity and prior authorization requirements as outlined above:
  - Surgical placement of implant body, endosteal or mini-implant is covered 1 time in a lifetime per tooth
  - Connecting bar, implant supported, or abutment supported is covered 1 time every 96 months, per arch.
  - Prefabricated or custom fabricated abutment is covered 1 time every 96 months, per arch.
  - Abutment supported crowns (porcelain/ceramic, porcelain fused to high noble, fused to base metal, fused to noble metal crown), or cast metal crowns (high noble, base metal or metal crown, noble metal, implant supported porcelain/ceramic or porcelain fused to high noble alloys, high noble alloys) are covered 1 time every 96 months per tooth.
  - Scaling and debridement in the presence of inflammation or mucositis of a single implant is covered 1 time every 12 months per tooth.
  - Repair implant supported prosthesis is covered 1 time every 12 months.
  - Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment is covered 1 time every 12 months, per quad.
  - Re-cement or re-bond implant, abutment supported crown is covered 1 time every 24 months per tooth.
  - Re-cement or re-bond implant, abutment supported FPD is covered 1 time every 24 months, per quad.
  - Abutment supported crown, titanium, and titanium alloys are covered 1 of every 96 months, per tooth.
  - Replacement of an implant screw (D6193) is covered 1 time per 12 months per implant
  - Implant removal.
  - Debridement of a peri-implant defect(s), surrounding single implant, including flap entry/closure or Debridement and osseous contouring of a peri-implant defect(s)

surrounding single implant, including flap entry/closure is covered 1 time every 24 months, per tooth.

- Bone graft for repair of peri-implant defect does not include flap entry and closure is covered 1 time every 24 months, per tooth.
- Bone graft at time of implant placement is covered 1 time in a lifetime per tooth.
- Implant/abutment supported removable denture is covered 1 time every 96 months, per arch.
- Radiographic/surgical implant index is covered 1 time every 12 months, per arch
- Semi-precision abutment or attachment placement is covered 1 time every 96 months per tooth.

Oral Surgery & Extractions - You are covered for the services below. Medical necessity and prior authorization is required on some services. A referral is required to see an oral surgeon except in the case of an emergency.

- You are covered for the routine removal of a tooth or teeth.
- More than 4 surgical extractions in 12 months require prior authorization.
- Removal of impacted teeth requires prior authorization.
- The allowance for extractions includes pre- and post-operative x-rays, post-operative care, and local anesthesia.

Please note:

- You are covered for other surgical procedures in or about the oral cavity if medically necessary and with prior authorization:
  - Alveoplasty requires prior authorization and is allowed 1 per lifetime per site/quad.
    - D7310 & D7311 will be reimbursed when additional surgical procedures beyond the removal of the teeth are required to prepare the ridge for dentures.
    - Not reimbursable in addition to surgical extractions in the same quadrant.
- All other oral surgery procedures, e.g., removal of foreign body, partial ostectomy, maxillary sinusotomy, closed or open reduction, alveolus, sinus augmentation, bone replacement graft for ridge preservation, per site, etc., require prior authorization and medical necessity.
  - Incisional biopsy of the oral tissue, hard and soft are covered 1 time every 12 months with prior authorization. When a provider performs surgical excision and removal of tumors, cysts and neoplasms, the extent of the procedure claimed must be supported by information in the member's record. This includes radiographic images, clinical findings, and operative and histopathologic reports.

- Buccal/labial frenectomy/frenulectomy allowed 3 times in a lifetime per arch. Lingual frenectomy/frenulectomy allowed 1 time per lifetime.
- Incision & drainage of abscess is covered as medically necessary.
- Excision of hyperplastic tissue is allowed 2 times per lifetime per arch.
- Excision of periocoronal gingiva allowed 1 time per 24 months per tooth.
- Surgical reduction of fibrous tuberosity is allowed 1 time per lifetime, per quad.
- Vestibuloplasty, ridge extensions are allowed 2 every 60 months with prior authorization. Vestibuloplasty may be approved when a denture could not otherwise be worn.

Anesthesia & Intravenous Sedation - You are covered for anesthesia under the following conditions below. Prior authorization is required.

- The anesthesia must be done for a covered service and can be given in or out of a hospital.
- Must be performed by a New York State licensed practitioner with the appropriate level of certification in Dental Anesthesia.
- Prior authorization is required for deep sedation/general anesthesia and Intravenous moderate conscious sedation/analgesia.
  - Deep sedation/general anesthesia is covered for a maximum of 60 minutes – 4 units and is not reimbursable with intravenous conscious sedation (D0239 or D0243).
  - Intravenous moderate conscious sedation/analgesia is covered for a maximum of 60 minutes – 4 units and is not reimbursable with deep sedation/general anesthesia (D9222 or D9223).
  - Local anesthesia is included in the allowance for the procedure being performed and does not require prior authorization.

Consultation – You are covered for:

- 1 (D9310) every 6 months is covered, per provider or location. Not reimbursable within 90 days of a D0120, D0140, D0150, D0160, D9110 or D9430 to the consulting dentist who assumes treatment.
- 1 eConsult (D9311) per week per provider. The requesting or consultative dentist will spend 15 minutes or more of dental consultative time. eConsults must not be used for the purpose of arranging a referral for an in-person visit.

Bedside Calls at home or in an extended care facility - You are covered for:

- 1 (D9410) per 1 day covered.
- Requires prior authorization and medical necessity.

Hospital or Ambulatory Surgical Center Call - You are covered for:

- 3 (D9420) per 1 week covered for professional visits for pre-operative or operative care. Requires prior authorization and medical necessity.

Other Limitations and Exclusions

- Providers must submit all necessary documents to prove the service meets the plan's criteria and is medically necessary. This includes full mouth X-rays and a treatment plan. Missing documents will lead to a denial of service. Services lacking enough documentation to show necessity, according to Liberty Dental's criteria, will be denied.
- Any procedure not specifically listed in this section as a covered dental benefit is not covered.
- Services related to 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 is not covered if it's due to civil insurrection, military service, acts of war, or nuclear incidents.
- 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 for missed appointments, preparing or copying dental reports, duplicate X-rays, itemized bills, or claim forms are not covered.

Services Not Within the Scope of this Coverage

These services include but are not limited to:

- Fixed bridgework, except for cleft palate stabilization or when a removable prosthesis, would be contraindicated.
- Immediate full or partial dentures.
- Crown lengthening except when associated with medically necessary crown or endodontic treatment.
- Dental work for cosmetic reasons or because of the personal preference of the member or provider.
- Periodontal surgery except when associated with implants or implant related services.
- Gingivectomy or gingivoplasty except for the sole correction of severe hyperplasia or hypertrophy associated with drug therapy, hormonal disturbances, or congenital defects.
- Adult orthodontics, except in conjunction with, or as a result of, approved orthognathic surgery necessary in conjunction with an approved course of orthodontic treatment or the on-going treatment of clefts.

- Improper usage of panoramic images (D0330) along with intraoral complete series of images (D0210).

Liberty Dental's criteria utilized for medical necessity determination were developed from information collected from American Dental Association's Code Manuals, clinical articles and guidelines, as well as dental schools, practicing dentists, insurance companies, other dental related organizations, and local state or health plan requirements.

Dental procedure codes and descriptions provided are based on CDT codes guidelines and intended for informational purposes only. These codes can change annually according to the updates released by the American Dental Association's Current Dental Terminology (CDT). These updates may introduce new codes, alter existing ones, or eliminate others. We recommend that you confirm the relevant procedure codes with our contracted dental vendor and dental provider before undergoing treatment to ensure they have the latest and most accurate information. The organization assumes no liability for claims denied due to the use of outdated or incorrect codes.

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
Diagnostic Services			
D0120	Periodic oral evaluation	No	1 (D0120) every 6 months
D0140	Limited oral evaluation	No	2 (D0140) every 12 months
D0145	Oral evaluation under age 3	No	
D0150	Comprehensive oral evaluation	No	1 (D0150) per provider per lifetime
D0160	Detailed and extensive oral evaluation – problem focused, by report	No	3 (D0160) every 12 months, by report
D0210	Intraoral, complete series of radiographic images	No	1 of (D0210, D0330) every 36 months if clinically indicated
D0220	Intraoral, periapical, first radiographic image	No	3 (D0220) every 6 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D0230	Intraoral, periapical, each additional radiographic image	No	3 (D0230) every 6 months
D0240	Intraoral, occlusal radiographic image	No	1 (D0240) per arch every 36 months
D0250	Extraoral 2D projection radiographic image, stationary radiation source	No	2 (D0250) every week, Not reimbursable for TMJ radiographs
D0272	Bitewings, two radiographic images	No	
D0273	Bitewings, three radiographic images	No	
D0251	Extra-oral posterior dental radiographic image	No	2 (D0251) every week, Not reimbursable for TMJ radiographs
D0270	Bitewing, single radiographic image	No	3 of (D0270-D0274) every 12 months
D0274	Bitewings, four radiographic images	No	
D0310	Sialography	No	2 (D0310) every week
D0320	TMJ arthrogram, including injection	No	2 (D0320) per lifetime
D0321	Other TMJ radiographic images, by report	No	2 (D0321) every 12 months, by report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D0330	Panoramic radiographic image	No	1 of (D0210, D0330) every 36 months if clinically indicated
D0340	2D cephalometric radiographic image, measurement and analysis	No	limited for OS purposes for handicapping malocclusion
D0350	2D oral/facial photographic image, intra-orally/extra-orally	No	1 (D0350) every 12 months, must be billed in conjunction with implants, orthodontics, or procedure codes D4210 & D4211
D0364	Cone beam CT capture & interpretation, limited view, less than one whole jaw	Yes	
D0365	Cone beam CT capture & interpretation, view of one full arch, mandible	Yes	
D0366	Cone beam CT capture & interpretation, view of one full arch, maxilla, cranium	Yes	
D0367	Cone beam CT capture & interpretation, view of both jaws; cranium	Yes	1 (D0367) every 60 months, limited to enrolled oral and maxillofacial surgeons
D0368	Cone beam CT capture and interpretation for TMJ series including two or more exposures	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D0470	Diagnostic casts	No	limited to orthodontists and oral and maxillofacial surgeons
D0474	Accession of tissue, gross/micro. exam, report	Yes	By Report, limited to oral pathologists
D0485	Consultation, including prep of slides, biopsy, referring source	Yes	By Report, limited to oral pathologists
D0502	Other oral pathology procedures, by report	Yes	By Report, limited to oral pathologists
D0999	Unspecified diagnostic procedure, by report	No	By Report
Preventive Services			
D1110	Prophylaxis, adult	No	1 of (D1110, D4910) every 6 months
D1206	Topical application of fluoride varnish	No	D1206 is only approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or discase. Effective 7.1.21 Up to Age 20 - 1 (D1206) every 3 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D1208	Topical application of fluoride, excluding varnish	No	1 (D1208) every 6 months. D1208 is only approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"), or, in cases where salivary gland function has been compromised through surgery, radiation, or disease.
D1320	Tobacco counseling, control/prevention oral disease	No	2 (D1320) every 12 months
D1354	Interim caries arresting medicament application, per tooth	No	D1354 is only approvable for those individuals identified with a recipient exception code of RE 81 ("TBI Eligible") or RE 95 ("OMRDD/Managed Care Exemption"). Limited to Silver Diamine Fluoride to stabilize non-symptomatic teeth with active carious lesions and no pulpal exposure.
D1999	Unspecified preventive procedure, by report	No	By Report
Restorative Services			

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D2140	Amalgam, one surface, primary or permanent	No	1 of (D2140–D2335,D2391–D2394) every 24 months, per tooth, per surface
D2150	Amalgam, two surfaces, primary or permanent	No	
D2160	Amalgam, three surfaces, primary or permanent	No	
D2161	Amalgam, four or more surfaces, primary or permanent	No	
D2330	Resin-based composite, one surface, anterior	No	
D2331	Resin-based composite, two surfaces, anterior	No	
D2332	Resin-based composite, three surfaces, anterior	No	
D2335	Resin-based composite, four or more surfaces, involving incisal angle	No	
D2390	Resin-based composite crown, anterior	No	1 (D2390) every 24 months, per tooth
D2391	Resin-based composite, one surface, posterior	No	1 of (D2140-D2335,D2391-D2394) every 24 months, per tooth, per surface

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D2392	Resin-based composite, two surfaces, posterior	No	
D2393	Resin-based composite, three surfaces, posterior	No	
D2394	Resin-based composite, four or more surfaces, posterior	No	
D2710	Crown, resin-based composite (indirect)	Yes	1 of (D2710-D2794) every 60 months, per tooth Prior Authorization required. Documentation needed: Diagnostic radiographs. Narrative and photographs if unable to take x-rays. 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. 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 must have a tooth above or below (depending on upper or lower crown being requested) touching it. Replacement of an existing

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			crown which, in the opinion of LIBERTY's Dental Director, is satisfactory or that can be made satisfactory is not covered. Cosmetic or experimental dental services, and/or procedures not generally performed in a general dentist office. 1) Crowns for the purposes of esthetics, or as a result of normal wear & attrition, recession, abfraction and/or abrasion are not covered. 2) Services requested without sufficient documentation to adequately review the services for necessity, as defined by Liberty's Clinical Criteria and Guidelines, will be denied. 3) Missing required documentation will result in the requested service being denied. 4) 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.
D2720	Crown, resin with high noble metal	Yes	
D2721	Crown, resin with predominantly base metal	Yes	
D2722	Crown, resin with noble metal	Yes	
D2740	Crown, porcelain/ceramic	Yes	
D2750	Crown, porcelain fused to high noble metal	Yes	
D2751	Crown, porcelain fused to predominantly base metal	Yes	
D2752	Crown, porcelain fused to noble metal	Yes	
D2753	Crown, porcelain fused to titanium and titanium	Yes	
D2780	Crown, % cast high noble metal	Yes	
D2781	Crown, % cast predominantly base metal	Yes	
D2782	Crown, % cast noble metal	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D2790	Crown, full cast high noble metal	Yes	
D2791	Crown, full cast predominantly base metal	Yes	
D2792	Crown, full cast noble metal	Yes	
D2794	Crown, titanium	Yes	
D2920	Re-cement or re-bond crown	No	1 (D2920) every 24 months, per tooth
D2931	Prefabricated stainless steel crown, permanent tooth	No	1 (D2931) every 60 months, per tooth
D2932	Prefabricated resin crown	No	1 (D2932) every 24 months, per tooth
D2933	Prefabricated stainless steel crown with resin window	No	1 (D2933) every 24 months, per tooth up to age 20
D2951	Pin retention, per tooth, in addition to restoration	No	2 (D2951) every 12 months, per tooth
D2952	Post and core in addition to crown, indirectly fabricated	No	1 of (D2952, D2954) every 60 months, per tooth
D2954	Prefabricated post and core in addition to crown	No	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D2955	Post removal	No	1 (D2955) every 60 months, per tooth
D2980	Crown repair necessitated by restorative material failure	Yes	1 (D2980) every 60 months, per tooth
D2999	Unspecified restorative procedure, by report	No	By Report
Endodontic Services			
D3220	Therapeutic pulpotomy (excluding final restoration)	No	1 (D3220) per lifetime per tooth, up to age 20
D3230	Pulpal therapy, anterior, primary tooth (excluding final restoration)	No	1 (D3230) per lifetime, per tooth, narrative and x-rays required with claim submission
D3240	Pulpal therapy, posterior, primary tooth (excluding final restoration)	No	1 (D3240) per lifetime, per tooth, narrative and x-rays required with claim submission
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	Yes	1 of (D3310-D3330) per lifetime, per tooth D3330 - molar endodontic therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or; where there is a documented

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			medical condition which precludes extraction.
D3320	Endodontic therapy, premolar tooth (excluding final restoration)	Yes	
D3330	Endodontic therapy, molar tooth (excluding final restoration)	Yes	
D3346	Retreatment of previous root canal therapy, anterior	Yes	1 of (D3346-D3348) per lifetime, per tooth, unless medically necessary
D3347	Retreatment of previous root canal therapy, premolar	Yes	
D3348	Retreatment of previous root canal therapy, molar	Yes	
D3410	Apicoectomy, anterior	Yes	1 of (D3410-D3425) per lifetime, per tooth D3425 - members age 21 and over, molar apicoectomy therapy will be considered only in those instances where the tooth in question is a critical abutment for an existing functional prosthesis and when the tooth cannot be extracted and replaced with a new prosthesis, or; where there is a documented medical condition

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			which preludes extraction.
D3421	Apicoectomy, premolar (first root)	Yes	
D3425	Apicoectomy, molar (first root)	Yes	
D3426	Apicoectomy, (each additional root)	Yes	1 (D3426) per lifetime, per tooth
D3430	Retrograde filling, per root	Yes	1 (D3430) per 1 lifetime, per tooth
D3999	Unspecified endodontic procedure, by report	No	By Report
Periodontal Services			
D4210	Gingivectomy or gingivoplasty, four or more teeth per quadrant	Yes	1 of (D4210, D4211) every 12 months, per quad, by report
D4211	Gingivectomy or gingivoplasty, one to three teeth per quadrant	Yes	
D4245	Apically positioned flap	Yes	
D4249	Clinical crown lengthening, hard tissue	Yes	1 (D4249) per tooth, per lifetime

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D4266	Guided tissue regeneration, resorbable barrier, per site	Yes	
D4267	Guided tissue regeneration, non-resorbable barrier, per site	Yes	
D4273	Autogenous connective tissue graft procedure, first tooth	Yes	
D4275	Non-autogenous connective tissue graft, first tooth	Yes	
D4277	Free soft tissue graft, first tooth	Yes	
D4278	Free soft tissue graft, each additional tooth	Yes	
D4283	Autogenous connective tissue graft procedure, each additional tooth, per site	Yes	
D4285	Non-autogenous connective tissue graft procedure, each additional tooth, per site	Yes	
D4341	Periodontal scaling and root planning, four or more teeth per quadrant	Yes - if within 24 months of original SRP	1 of (D4341, D4342) every 24 months, per site/quad

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D4342	Periodontal scaling and root planning, one to three teeth per quadrant		
D4910	Periodontal maintenance	No	1 of (D1110, D4910) every 6 months. Members who are developmentally disabled may be eligible 4 times per 12 months.
D4999	Unspecified periodontal procedure, by report	No	By Report
Removable Prosthodontic Services			
D5110	Complete denture, maxillary	Yes	1 of (D5110, D5120) every 96 months, per arch
D5120	Complete denture, mandibular	Yes	
D5211	Maxillary partial denture, resin base	Yes	1 of (D5211-D5226) every 96 months, per arch
D5212	Mandibular partial denture, resin base	Yes	
D5213	Maxillary partial denture, cast metal, resin base	Yes	
D5214	Mandibular partial denture, cast metal, resin base	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5225	Maxillary partial denture, flexible base	Yes	
D5226	Mandibular partial denture, flexible base	Yes	
D5410	Adjust complete denture, maxillary	No	4 of (D5410-D5422) every 12 months, per arch. Not covered within 6 months of placement
D5411	Adjust complete denture, mandibular	No	
D5421	Adjust partial denture, maxillary	No	
D5422	Adjust partial denture, mandibular	No	
D5511	Repair broken complete denture base, mandibular	No	2 of (D5511, D5512) every 12 months, per arch
D5512	Repair broken complete denture base, maxillary	No	
D5520	Replace missing or broken teeth – complete denture – per tooth	No	1 (D5520) every 12 months, per tooth
D5611	Repair resin partial denture base, mandibular	No	2 of (D5611, D5612) every 12 months, per arch

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5612	Repair resin partial denture base, maxillary	No	
D5621	Repair cast partial framework, mandibular	No	1 of (D5621, D5622) every 12 months, per arch
D5622	Repair cast partial framework, maxillary	No	
D5630	Repair or Replace broken retentive clasping materials, per tooth	No	2 (D5630) every 12 months, per tooth
D5640	Replace missing or broken teeth – partial denture - per tooth	No	1 (D5640) every 12 months, per tooth
D5650	Add tooth to existing partial denture – per tooth	No	1 (D5650) every 12 months, per tooth
D5660	Add clasp to existing partial denture, per tooth	No	1 (D5660) every 12 months
D5710	Rebase complete maxillary denture	No	1 of (D5710, D5711) every 60 months per arch Not payable within 6 months of original seat date
D5711	Rebase complete mandibular denture	No	
D5720	Rebase maxillary partial denture	No	1 of (D5720, D5721) every 60 months, per arch Not payable

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			within 6 months of original seat date
D5721	Rebase mandibular partial denture	No	
D5730	Reline complete maxillary denture, chairside	No	1 of (D5730, D5731) every 12 months, per arch Not payable within 6 months of original seat date
D5731	Reline complete mandibular denture, chairside	No	
D5740	Reline maxillary partial denture, chairside	No	1 of (D5740, D5741) every 12 months, per arch Not payable within 6 months of original seat date
D5741	Reline mandibular partial denture, chairside	No	
D5750	Reline complete maxillary denture, laboratory	No	1 of (D5750, D5751) every 24 months, per arch Not payable within 6 months of original seat date
D5751	Reline complete mandibular denture, laboratory	No	
D5760	Reline maxillary partial denture, laboratory	No	1 of (D5760, D5761) every 24 months, per arch Not payable within 6 months of original seat date
D5761	Reline mandibular partial denture, laboratory	No	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5850	Tissue conditioning, maxillary	No	1 of (D5850, D5851) every 60 months, per arch One per denture prior to reline, rebase, or impression for new denture. Not payable within six (6) months prior to the delivery of a new prosthesis
D5851	Tissue conditioning, mandibular	No	
D5899	Unspecified removable prosthodontic procedure, by report	No	By Report
Maxillofacial Prosthetic Services			
D5911	facial moulage (sectional)	Yes	1 (D5911) every 12 months
D5912	facial moulage (complete)	Yes	1 (D5912) every 12 months
D5913	Nasal prosthesis	Yes	1 (D5913) every 12 months
D5914	Auricular prosthesis	Yes	1 (D5914) every 12 months
D5915	Orbital prosthesis	Yes	1 (D5915) every 12 months
D5916	Ocular prosthesis	Yes	1 (D5916) every 12 months
D5919	facial prosthesis	Yes	6 (D5919) every 2 months
D5922	Nasal septal prosthesis	Yes	1 (D5922) every 12 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5923	Ocular prosthesis, interim	Yes	1 (D5923) every 12 months
D5924	Cranial prosthesis	Yes	1 (D5924) every 12 months
D5925	facial augmentation implant prosthesis	Yes	1 (D5925) every 12 months
D5926	Nasal prosthesis, Replacement	Yes	1 (D5926) every 12 months
D5927	Auricular prosthesis, Replacement	Yes	1 (D5927) every 12 months
D5928	Orbital prosthesis, Replacement	Yes	1 (D5928) every 12 months
D5929	facial prosthesis, Replacement	Yes	1 (D5929) every 12 months
D5931	Obturator prosthesis, Surgical	Yes	1 (D5931) every 12 months
D5932	Obturator prosthesis, definitive	Yes	1 (D5932) every 12 months
D5933	Obturator prosthesis, modification	Yes	1 (D5933) every 6 months
D5934	Mandibular resection prosthesis with guide flange	Yes	1 (D5934) every 12 months
D5935	Mandibular resection prosthesis without guide flange	Yes	1 (D5935) every 12 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5936	Obturator prosthesis, interim	Yes	1 (D5936) every 12 months
D5937	Trismus Appliance (not for TMD treatment)	Yes	1 (D5937) every 12 months
D5951	Feeding aid	Yes	1 (D5951) every 12 months
D5952	Speech aid prosthesis, pediatric	Yes	1 (D5952) every 12 months, Up to age 20
D5953	Speech aid prosthesis, adult	Yes	1 (D5953) every 12 months
D5954	Palatal augmentation prosthesis	Yes	1 (D5954) every 12 months
D5955	Palatal lift prosthesis, definitive	Yes	1 (D5955) every 12 months
D5958	Palatal lift prosthesis, interim	Yes	1 (D5958) every 12 months
D5959	Palatal lift prosthesis, modification	Yes	1 (D5959) every 12 months
D5960	Speech aid prosthesis, modification	Yes	1 (D5960) every 12 months
D5982	Surgical stent	Yes	1 (D5982) every 12 months
D5983	Radiation barrier	Yes	1 (D5983) every 12 months
D5984	Radiation shield	Yes	1 (D5984) every 12 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D5985	Radiation eone locator	Yes	1 (D5985) every 12 months
D5986	FIuoride geI carrier	Yes	2 (D5986) every 12 months, per arch
D5987	Commissure splint	Yes	1 (D5987) every 12 months
D5988	Surgical splint	Yes	1 (D5988) every 12 months
D5999	Unspecified maxiIlofacial prosthesis, by report	No	
Implant Services *See Dental Implant Benefit documentation listed at the bottom of this schedule for benefit guidelines			
D6010	Surgical placement of implant body, endosteal	Yes	1 of (D6010, D6013) in a lifetime, per tooth
D6013	Surgical placement of mini implant	Yes	
D6055	Connecting bar, implant supported or abutment supported	Yes	1 (D6055) every 96 months, per arch
D6056	Prefabricated abutment, includes modification and placement	Yes	1 of (D6056, D6057) every 96 months, per tooth
D6057	Custom fabricated abutment, includes placement	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6058	Abutment supported porcelain/ceramic crown	Yes	1 of (D6058-D6067, D6094) every 96 months, per tooth
D6059	Abutment supported porcelain fused to high noble crown	Yes	
D6060	Abutment supported porcelain fused to base metal crown	Yes	
D6061	Abutment supported porcelain fused to noble metal crown	Yes	
D6062	Abutment supported cast metal crown, high noble	Yes	
D6063	Abutment supported cast metal crown, base metal	Yes	
D6064	Abutment supported cast metal crown, noble metal	Yes	
D6065	Implant supported porcelain/ceramic crown	Yes	
D6066	Implant supported crown, porcelain fused to high noble alloys	Yes	
D6067	Implant supported crown, high noble alloys	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	Yes	1 (D6081) every 12 months, per tooth
D6090	Repair of implant/abutment supported prosthesis	Yes	1 (D6090) every 12 months
D6091	Replacement of semi-precision, precision attachment, implant/abutment supported prosthesis, per attachment	Yes	1 (D6091) every 12 months, per quad
D6092	Re-cement or re-bond implant/abutment supported crown	Yes	1 (D6092) every 24 months, per tooth
D6093	Re-cement or re-bond implant/abutment supported FPD	Yes	1 (D6093) every 24 months, per quad
D6094	Abutment supported crown, titanium, and titanium alloys	Yes	1 of (D6058-D6067, D6094) every 96 months, per tooth
D6095	Repair implant abutment, by report	Yes	1 (D6095) every 12 months, per tooth

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6096	Remove broken implant retaining screw	Yes	1 (D6096) every 12 months, per tooth
D6100	Implant removal, by report	Yes	
D6101	Debridement of a peri-implant defect(s), surrounding single implant, including flap entry/closure	Yes	1 (D6101) every 24 months, per tooth
D6102	Debridement and osseous contouring of a peri-implant defect(s) surrounding single implant, including flap entry/closure	Yes	1 (D6102) every 24 months, per tooth
D6103	Bone graft for repair of peri-implant defect, does not include flap entry and closure	Yes	1 (D6103) every 24 months, per tooth
D6104	Bone graft at time of implant placement	Yes	1 (D6104) in a lifetime, per tooth
D6110	Implant/abutment supported removable denture, maxillary	Yes	
D6111	Implant/abutment supported removable denture, mandibular	Yes	1 of (D6110-D6113) every 96 months, per arch

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6112	Implant/abutment supported removable denture, partial, maxillary	Yes	
D6113	Implant/abutment supported removable denture, partial, mandibular	Yes	
D6190	radiographic/Surgical implant index, by report	Yes	1 (D6190) every 12 months, per arch
D6191	Semi-precision abutment, placement	Yes	1 (D6191) every 96 months, per tooth
D6192	Semi-precision attachment, placement	Yes	1 (D6192) every 96 months, per tooth
D6199	Unspecified implant procedure, by report	Yes	By Report
Fixed Prosthodontic Services			
D6210	Pontic, cast high noble metal	Yes	1 of (D6210-D6794) every 60 months, per tooth Fixed bridgework is generally considered beyond the scope of the NYS Medicaid program. The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the mouth in those exceptional cases where there is a documented physical or neurological disorder

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			that would prelude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization. In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.
D6211	Pontic, cast predominantly base metal	Yes	
D6212	Pontic, cast noble metal	Yes	
D6214	Pontic, titanium, and titanium alloys	Yes	
D6240	Pontic, porcelain fused to high noble metal	Yes	
D6241	Pontic, porcelain fused to predominantly base metal	Yes	
D6242	Pontic, porcelain fused to noble metal	Yes	
D6243	Pontic, porcelain fused to titanium and titanium alloys	Yes	
D6245	Pontic, porcelain/ceramic	Yes	1 of (D6210-D6794) every 60 months, per tooth Fixed bridgework is generally considered beyond the scope of the NYS Medicaid program. The placement of a fixed prosthetic appliance will only be considered for the anterior segment of the

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			mouth in those exceptional cases where there is a documented physical or neurological disorder that would preclude placement of a removable prosthesis, or in those cases requiring cleft palate stabilization. In cases other than for cleft palate stabilization, treatment would generally be limited to replacement of a single maxillary anterior tooth or replacement of two adjacent mandibular teeth.
D6250	Pontic, resin with high noble metal	Yes	
D6251	Pontic, resin with predominantly base metal	Yes	
D6252	Pontic, resin with noble metal	Yes	
D6545	Retainer, cast metal for resin bonded fixed prosthesis	Yes	
D6720	Retainer crown, resin with high noble metal	Yes	
D6721	Retainer crown, resin with predominantly base metal	Yes	
D6722	Retainer crown, resin with noble metal	Yes	
D6740	Retainer crown, porcelain/ceramic	Yes	
D6750	Retainer crown, porcelain fused to high noble metal	Yes	
D6751	Retainer crown, porcelain fused to predominantly base metal	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6752	Retainer crown, porcelain fused to noble metal	Yes	
D6753	Retainer crown, porcelain fused to titanium and titanium alloys	Yes	
D6780	Retainer crown, % cast high noble metal	Yes	
D6781	Retainer crown, % cast predominantly base metal	Yes	
D6782	Retainer crown, % cast noble metal	Yes	
D6783	Retainer crown, % porcelain/ceramic	Yes	
D6784	Retainer crown %, titanium and titanium alloys	Yes	
D6790	Retainer crown, full cast high noble metal	Yes	
D6791	Retainer crown, full cast predominantly base metal	Yes	
D6792	Retainer crown, full cast noble metal	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D6794	Retainer crown, titanium and titanium alloys	Yes	
D6930	Re-cement or re-bond fixed partial denture	No	1 (D6930) every 24 months, per site
D6980	Fixed partial denture repair, restorative material failure	No	1 (D6980) every 60 months, per site
D6999	Unspecified fixed prosthodontic procedure, by report	No	By Report
Oral & Maxillofacial Surgical Services			
D7111	Extraction, coronal remnants, primary tooth	No	
D7140	Extraction, erupted tooth or exposed root	No	
D7210	Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth	Yes - if more than 4 Extractions in 12 months	
D7220	Removal of impacted tooth, soft tissue	Yes	
D7230	Removal of impacted tooth, partially bony	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7240	Removal of impacted tooth, completely bony	Yes	
D7241	Removal impacted tooth, complete bony, complication	Yes	By Report
D7250	Removal of residual tooth roots (cutting procedure)	No	Review for Medical Necessity
D7260	Oroantral fistula closure	No	Review for Medical Necessity
D7261	Primary closure of a sinus perforation	No	Review for Medical Necessity
D7270	Tooth reimplantation and/or stabilization, accident	No	
D7272	Tooth transplantation	No	
D7280	Exposure of an unerupted tooth	No	through age 23
D7283	Placement, device to facilitate eruption, impaction	No	through age 23
D7285	Incisional biopsy of oral tissue, hard (bone, tooth)	Yes	1 (D7285) every 12 months
D7286	Incisional biopsy of oral tissue, soft	Yes	1 (D7286) every 12 months

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7290	Surgical repositioning of teeth	Yes	
D7310	Alveoloplasty with Extractions, four or more teeth per quadrant	Yes	1 of (D7310-D7321) per lifetime, per site/quad D7310 &D7311 - This procedure will be reimbursed when additional surgical procedures above and beyond the removal of the teeth are required to prepare the ridge for dentures. Not reimbursable in addition to surgical extractions in the same quadrant.
D7311	Alveoloplasty with Extractions, one to three teeth per quadrant	Yes	
D7320	Alveoloplasty, w/o Extractions, four or more teeth per quadrant	No	
D7321	Alveoloplasty, w/o Extractions, one to three teeth per quadrant	No	
D7340	Vestibuloplasty, ridge extension (2nd epithelialization)	Yes	2 of (D7340, D7350) every 60 months
D7350	Vestibuloplasty, ridge extension	Yes	
D7410	Excision of benign lesion, up to 1.25 cm	Yes	By Report
D7411	Excision of benign lesion, greater than 1.25 cm	Yes	By Report
D7412	Excision of benign lesion, complicated	Yes	By Report
D7413	Excision of malignant lesion, up to 1.25 cm	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7414	Excision of malignant lesion, greater than 1.25 cm	Yes	By Report
D7415	Excision of malignant lesion, complicated	Yes	By Report
D7440	Excision of malignant tumor, up to 1.25 cm	Yes	By Report
D7441	Excision of malignant tumor, greater than 1.25 cm	Yes	By Report
D7450	Removal, benign odontogenic cyst/tumor, up to 1.25 cm	Yes	By Report
D7451	Removal, benign odontogenic cyst/tumor, greater than 1.25 cm	Yes	By Report
D7460	Removal, benign nonodontogenic cyst/tumor, up to 1.25 cm	Yes	By Report
D7461	Removal, benign nonodontogenic cyst/tumor, greater than 1.25 cm	Yes	By Report
D7465	Destruction of lesion(s) by physical or chemical method, by report	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7471	Removal of lateral exostosis, maxilla or mandible	Yes	1 (D7471) in a lifetime, per quad
D7472	Removal of torus palatinus	Yes	By Report
D7473	Removal of torus mandibularis	Yes	By Report
D7485	Reduction of osseous tuberosity	Yes	1 (D7485) in a lifetime, per quad
D7490	Radical resection of maxilla or mandible	Yes	By Report
D7510	Incision & drainage of abscess, intraoral soft tissue	No	By Report, narrative required with claim submission
D7511	Incision & drainage of abscess, intraoral soft tissue, complicated	No	By Report, narrative required with claim submission
D7520	Incision & drainage of abscess, extraoral soft tissue	No	By Report, narrative required with claim submission
D7521	Incision & drainage of abscess, extraoral soft tissue, complicated	No	By Report, narrative required with claim submission
D7530	Remove foreign body, mucosa, skin, tissue	Yes	By Report
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7550	Partial osteotomy/sequestrectomy for removal of non-vital bone	Yes	By Report
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	Yes	By Report
D7610	Maxilla, open reduction (teeth immobilized, if present)	Yes	By Report
D7620	Maxilla, closed reduction (teeth immobilized, if present)	Yes	By Report
D7630	Mandible, open reduction (teeth immobilized, if present)	Yes	By Report
D7640	Mandible, closed reduction (teeth immobilized, if present)	Yes	By Report
D7650	Malar and/or zygomatic arch, open reduction	Yes	By Report
D7660	Malar and/or zygomatic arch, closed reduction	Yes	By Report
D7670	Alveolus, closed reduction, may include stabilization of teeth	Yes	By Report
D7671	Alveolus, open reduction, may include stabilization of teeth	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7680	facial bones, complicated reduction with fixation, multiple Surgical approaches	Yes	By Report
D7710	Maxilla, open reduction	Yes	By Report
D7720	Maxilla, closed reduction	Yes	By Report
D7730	Mandible, open reduction	Yes	By Report
D7740	Mandible, closed reduction	Yes	By Report
D7750	Malar and/or zygomatic arch, open reduction	Yes	By Report
D7760	Malar and/or zygomatic arch, closed reduction	Yes	By Report
D7770	Alveolus, open reduction stabilization of teeth	Yes	By Report
D7771	Alveolus, closed reduction stabilization of teeth	Yes	By Report
D7780	facial bones, complicated reduction with fixation and multiple approaches	Yes	By Report
D7810	Open reduction of dislocation	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7820	Closed reduction of dislocation	Yes	By Report
D7830	Manipulation under anesthesia	Yes	By Report
D7840	Condylectomy	Yes	By Report
D7850	Surgical discectomy, with/without implant	Yes	2 (D7850) in a lifetime
D7852	Disc repair	Yes	2 (D7852) in a lifetime
D7854	Synovectomy	Yes	2 (D7854) in a lifetime
D7856	Myotomy	Yes	2 (D7856) in a lifetime
D7858	Joint reconstruction	Yes	2 (D7858) in a lifetime
D7860	Arthrotomy	Yes	2 (D7860) in a lifetime
D7865	Arthroplasty	Yes	2 (D7865) in a lifetime
D7870	Arthrocentesis	Yes	1 (D7870) every 6 months
D7872	Arthroseopy, diagnosis, with or without biopsy	Yes	2 (D7872) in a lifetime
D7873	Arthroseopy: lavage and lysis of adhesions	Yes	2 (D7873) in a lifetime

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7874	Arthroscopy: disc repositioning and stabilization	Yes	2 (D7874) in a lifetime
D7875	Arthroscopy: synovectomy	Yes	2 (D7875) in a lifetime
D7876	Arthroscopy: discectomy	Yes	2 (D7876) in a lifetime
D7877	Arthroscopy: debridement	Yes	2 (D7877) in a lifetime
D7880	occlusal orthotic device, by report	Yes	1 (D7880) every 12 months
D7899	Unspecified TMD therapy, by report	Yes	By Report
D7910	Suture of recent small wounds up to 5 cm	Yes	By Report
D7911	Complicated suture, up to 5 cm	Yes	By Report
D7912	Complicated suture, greater than 5 cm	Yes	By Report
D7920	Skin graft (identify defect covered, location and type of graft)	Yes	By Report
D7940	Osteoplasty, for orthognathic deformities	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7941	Osteotomy, mandibular rami	Yes	By Report
D7943	Osteotomy, mandibular rami with bone graft; includes obtaining the graft	Yes	By Report
D7944	Osteotomy, segmented or subapical	Yes	By Report
D7945	Osteotomy, body of mandible	Yes	By Report
D7946	LeFort I (maxilla, total)	Yes	By Report
D7947	LeFort I (maxilla, segmented)	Yes	By Report
D7948	LeFort II or LeFort III, without bone graft	Yes	By Report
D7949	LeFort II or LeFort III, with bone graft	Yes	By Report
D7950	Osseous, osteoperiosteal, cartilage graft, mandible or maxilla, by report	Yes	By Report
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7952	Sinus augmentation via a vertical approach	Yes	
D7953	Bone Replacement graft for ridge preservation, per site	Yes	
D7961	Buccal / labial frenectomy (frenulectomy)	Yes	3 (D7961) in a lifetime, per arch
D7962	Lingual frenectomy (frenulectomy)	Yes	1 (D7962) in a lifetime
D7970	Excision of hyperplastic tissue, per arch	Yes	2 (D7970) in a lifetime, per arch
D7971	Excision of pericoronal gingiva	Yes	1 (D7971) every 24 months, per tooth
D7972	Surgical reduction of fibrous tuberosity	Yes	1 (D7972) in a lifetime, per quad
D7980	Surgical Sialolithotomy	Yes	By Report
D7981	Excision of salivary gland, by report	Yes	By Report
D7982	Sialodochoplasty	Yes	By Report
D7983	Closure of salivary fistula	Yes	By Report

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D7990	Emergency tracheotomy	No	By Report
D7991	Coronoidectomy	Yes	1 (D7991) in a lifetime
D7997	Appliance removal (not by dentist who placed Appliance), includes removal of archbar	Yes	By Report
D7998	Intraoral placement of a fixation device not in conjunction with a fracture	Yes	By Report
D7999	Unspecified oral surgery procedure, by report	No	By Report
Adjunctive General Services			
D9110	Palliative (Emergency) treatment, minor procedure	No	2 (D9110) every 12 months. Not reimbursable in addition to other therapeutic services performed at the same visit or in conjunction with initial or periodic oral examinations.
D9120	Fixed partial denture sectioning	Yes	By Report
D9222	Deep sedation/general anesthesia, first 15 minute increment	Yes	Maximum of 60 minutes - 4 units. Will only be reimbursable when provided by a qualified dental provider who has the appropriate level of certification in Dental Anesthesia. Not to be combined with D9239, D9243. If additional

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
			units are necessary, documentation of medical necessity required with claim submission.
D9223	Deep sedation/general anesthesia, each subsequent 15 minute increment	Yes	
D9230	Inhalation of nitrous oxide/analgesia, anxiolysis	No	NY Medicaid manual, page 81: "The cost of analgesic and anesthetic agents is included in the reimbursement for the dental service. The administration of nitrous oxide is not separately reimbursable."
D9239	Intravenous moderate (conscious) sedation/analgesia, first 15 minute increment	Yes	Maximum of 60 minutes - 4 units. Will only be reimbursable when provided by a qualified dental provider who has the appropriate level of certifieation in Dental Anesthesia. Not to be combined with D9222, D9223. If additional units are necessary, documentation of medical necessity required with claim submission.
D9243	Intravenous moderate (conscious) sedation/analgesia, each subsequent 15 minute increment	Yes	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D9310	Consultation, other than requesting dentist	No	1 (D9310) every 6 months, per provider or location Will not be reimbursed within 90 days of D0120, D0140, D0150, D0160, D9110 or D9430 to consulting dentist who assumes treatment
D9410	House/extended care facility call	Yes	1 (D9410) per 1 day. Reimbursement is per visit, regardless of number of beneficiaries seen
D9420	Hospital or ambulatory Surgical center call	Yes	3 (D9420) per 1 week, By Report. Professional visits for pre-operative or operative care
D9430	Office visit, observation, regular hours, no other services	No	4 (D9430) every 12 months, By Report. Cannot be used with any treatment codes or case management (D9997) on the same date of service. Limited to specialists for non-referred patients. Used to monitor the status of a beneficiary following an authorized phase of surgical treatment that are required beyond the follow up period for that procedure listed in the fee schedule. Not be used for orthodontic retention follow-up visits

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D9440	Office visit, after regularly scheduled hours	No	1 (D9440) per day, not payable in conjunction with an examination, observation, or consultation.
D9610	Therapeutic parenteral drug, single administration	No	
D9944	occlusal guard, hard Appliance, full arch	Yes	1 (D9944-D9946) every 12 months
D9945	occlusal guard, soft Appliance, full arch	Yes	
D9946	occlusal guard, hard Appliance, partial arch	Yes	
D9990	Certified translation or sign-language services, per visit	No	Narrative of certified translator required with claim submission
D9995	Teledentistry, synchronous; real-time encounter	No	
D9996	Teledentistry, asynchronous; information stored and forwarded to dentist for subsequent review	No	

Code Set			
Code	**Description**	**Pre Authorization Required?**	**Limitations**
D9997	Dental case management, patients with special health care needs	No	Not billable as a "stand alone" procedure or in combination with deep sedation/general anesthesia. Another billable clinical service must be provided on the same date of service. For developmentally disabled population (OMRDD Clients). Narrative of medical necessity required with claim. A copy of the completed OMRDD client identification letter must be attached to each claim.
D9999	Unspecified adjunctive procedure, by report	Yes	By Report
Q3014	Telehealth originating site facility fee	No	

Implant Benefit Guideline Criteria:

Dental implants will be covered by Medicaid when medically necessary. Prior approval requests for implants must have supporting documentation from the patient's physician and dentist. A letter from the patient's physician must explain how implants will alleviate the patient's medical condition. A letter from the patient's dentist must explain why other covered functional alternatives for prosthetic replacement will not correct the patient's dental condition and why the patient requires implants.

General Guidelines:

A complete treatment plan addressing all phases of care is required and should include the following:

- Accurate pretreatment charting;
- Complete treatment plan addressing all areas of pathology;
- Inter-arch distances;

- Number, type and location of implants to be placed;
- Design and type of planned restoration(s);
- Sufficient number of current, diagnostic radiographs and/or CT scans allowing for the evaluation of the entire dentition.

If bone graft augmentation is needed, there must be a 4 to 6-month healing period before a dental implant can be placed.

- Dental implant code D6010 will be re-evaluated via intraoral radiographs or CT scans prior to the authorization of abutments, crowns, or dentures four to six months after dental implant placement.
- Treatment on an existing implant / implant prosthetic will be evaluated on a case-by-case basis.
- Implant and implant related codes not listed will be considered on a case-by-case basis.
- Physician's documentation must include a list of all medications currently being taken and all conditions currently being treated.
- All cases will be considered based upon supporting documentation and current standard of care.

For procedure codes D6010 and D6013, the following must be submitted:

- Full mouth radiographs or a diagnostic panorex including periapicals of site requesting dental implant(s).

SECTION 3 Services covered outside of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP)

There are services that are not covered or may not be fully covered by Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), but are available through Medicaid. If you have questions about the Medicaid assistance you get please review your Medicaid Member Handbook or contact your state Medicaid office at the phone number listed in Chapter 2, Section 6 of this document.

The following services are not covered by Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) but are available through Medicaid.

Services Covered by Medicaid Fee-for-Service

- Out of network Family Planning services under the direct access provisions,
- Medicaid Pharmacy Benefits as allowed by State Law (select drug categories excluded from the Medicare Part D benefit),
- Methadone Maintenance Treatment Programs,
- Certain Mental Health Services, including

- Intensive Psychiatric Rehabilitation Treatment Programs,
- Day Treatment,
- Continuing Day Treatment,
- Case Management for Seriously and Persistently Mentally Ill (sponsored by state or local mental health units),
- Partial Hospitalizations,
- Assertive Community Treatment (ACT),
- Personalized Recovery Oriented Services (PROS),
- Rehabilitation Services Provided to Residents of OMH Licensed Community Residences (CRs) and Family Based Treatment Programs,
- Office for People With Developmental Disability Services,
- Comprehensive Medicaid Case Management,
- Home and Community Based Waiver Program Services,
- Directly Observed Therapy for Tuberculosis Disease, and
- Assisted Living Program

Medicaid benefits

The benefits listed below are covered by your plan under New York State Medicaid Program.

The benefits mentioned earlier in this Evidence of Coverage are covered by Medicare. For each benefit listed below, you can see what New York State Medicaid Program covers and what our plan covers. What you pay for covered services may depend on your level of Medicaid eligibility.

Members with full Medicaid benefits may get the following services through the Medicaid program:

The benefits listed in this chart reflect Medicaid coverage at the time this Evidence of Coverage was published. Medicaid benefits may change during the year based on state or federal requirements. For the most current Medicaid benefit information, please contact Customer Service or visit your state Medicaid website https://www.health.ny.gov/health_care/medicaid/.

Benefit Category	New York State Medicaid Program
Abortion Elective abortion is performed when a pregnant female chooses to terminate the life of the fetus rather than continue with the pregnancy. Elective abortion is a medically-induced event. Therapeutic abortion, also known as spontaneous abortion or miscarriage, is the loss or death of a fetus prior to the age of viability from natural causes or traumatic events, that is, from non-medically induced causation.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Behavioral Health/Substance Abuse - Crisis Intervention/Stabilization Crisis Intervention/Stabilization services are provided to those experiencing a psychiatric crisis, are designed to interrupt and/or ameliorate a crisis experience including a preliminary assessment, immediate crisis resolution and de-escalation. The goals of crisis interventions/stabilizations are engagement, symptom reduction, stabilization, and restoring members to previous level of functioning. Services include, but may not be limited to, the following components: • a) Referral and linkage to appropriate community services to avoid more restrictive levels of treatment.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
• b) A preliminary assessment of risk, mental status, and medical stability; and the need for further evaluation or other mental health services. Includes contact with the member, family, or other collateral sources (e.g. physician or qualified provider, caregiver, school personnel) with pertinent information for the purpose of a preliminary assessment, treatment and/or referral to other alternative mental health services at an appropriate level. • c) May include admission to a more intensive level of care.	
Behavioral Health/Substance Abuse - Intensive Outpatient Program (IOP) - Facility Outpatient facility based program aimed at improving a member's functioning level to prevent relapse or hospitalization. Program usually meets several times a week for at least three (3) hours of behavioral health or substance abuse services.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Behavioral Health/Substance Abuse - Inpatient Services Medically necessary services that include, but are not limited to: • Psychiatric services for children, adolescents and adults provided in an acute care or free standing psychiatric hospital. • Detoxification and/or rehabilitation services for substance or alcohol abuse in an inpatient hospital setting. Alcohol and substance abuse treatment and services are aimed to achieve the mental and physical restoration of alcohol and drug abusers.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
• Services may be provided by psychiatrists, psychologists, clinical social workers, therapists, and medical doctors or specialists. • Crisis stabilization may be a short term inpatient intervention at a facility designed to restore the member to a level of functioning that does not require hospitalization.	
Behavioral Health/Substance Abuse - Outpatient Services Outpatient Services are generally covered for the treatment of mental health and substance abuse issues. 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. Services may include but are not limited to: assessment and diagnosis, basic medical and therapeutic services, crisis services/respite, individual, family and/or group therapy, medication management, ambulatory detoxification, medication assisted treatment (MAT for opioid addiction disorders), rehabilitation services, and case management services.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Behavioral Health/Substance Abuse - Partial Hospital-Facility Structured facility based program provided in an outpatient setting, offering a variety of behavioral health/substance abuse treatment services as an alternative to inpatient care that is more intense than care rendered in a physician's or therapist's office.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Behavioral Health/Substance Abuse - Residential Treatment Centers A residential treatment center is a facility which provides a total 24 hour therapeutically planned and professionally staffed group living and learning environment. • For substance abuse, a facility provides treatment for alcohol and drug abuse to live-in residents who do not require acute medical care. • For psychiatric problems, a facility offers mental health treatment to children and adolescents who do not require the intensity of acute inpatient care. • Services may include but are not limited to: Individual, group, and family therapy along with medication management, medical treatment, lab testing, and room and board.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Residential eating disorder treatment services are not covered. Contact your Medicaid Agency for additional details.
Blood Administration and Other Blood Products Storage and administration of blood or blood components lost or damaged through surgery, trauma or disease.	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Cardiac Rehabilitation Services Cardiac rehabilitation is a program recommended for patients who have had a heart attack, angina, congestive heart failure, or other forms of heart disease or those who have undergone heart surgery. A cardiac rehabilitation program includes counseling and information about the patient's condition; a supervised exercise program; lifestyle and risk factor modification programs such as smoking cessation, information on nutrition	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
and controlling high blood pressure; and emotional and social support.	
Chemotherapy/Radiation Chemotherapy is the treatment of cancer with an antineoplastic drug or with a combination of such drugs into a standardized treatment regimen. Therapeutic radiology (also called Radiation Oncology) is the treatment of cancer and other diseases with radiation.	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Cosmetic/Plastics/Reconstructive Procedures Cosmetic surgery includes any surgical procedure to enhancing a patients appearance to improve aesthetic appeal, symmetry, and/or proportion in the absence of accidental injury or a malformed body member. Reconstructive surgery includes surgical procedures whose goal is intended to restore form and function in structures deformed or damaged by disease, congenital anomaly, tumor, trauma, or infection.	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Dental Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the mouth or teeth. • Dental (Accident/Injury Only): Dental services associated with the structure of the oral cavity and contiguous tissues due to injury, or impairment which may affect the oral or general health of the individual. • Dental (Preventive, Restorative): Any diagnostic, preventive, or corrective dental procedures administered by or under the direct personal	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
supervision of a dentist in the practice of the practitioner's profession. • Dental (Orthodontics): Orthodontics is a specialty of dentistry concerned with the study and treatment of malocclusions (improper bites), which may be a result of tooth irregularity, disproportionate jaw relationships, or both.	
Durable Medical Equipment (DME) Durable Medical Equipment is primarily and customarily used to serve a medical purpose, is appropriate for use in the home, and can withstand repeated use, and includes adaptive equipment/aids, humidifiers, oxygen and related respiratory equipment, nebulizers, and glucometers. DME does not include disposable medical supplies.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Drugs A medicine or other chemical substance which has a physiological effect when ingested or otherwise introduced into the body; used to treat, cure, prevent, or diagnose a disease or to promote well-being. Includes prescription drugs and over-the-counter drugs, whether purchased at a pharmacy or administered by a licensed medical professional, such as a physician.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Drugs prescribed for cosmetic purposes are not covered. Risperidone microspheres (Risperdal Consta), Paliperidone Palmitate (Invega Sustenna) and Olanzapine (Zyprexxa Releprevv) will remain carved out and are covered through Fee-for Service for SSI/SSI-related enrollees in mainstream Medicaid managed care plans. Drugs for the treatment of erectile dysfunction are not covered.

Benefit Category	New York State Medicaid Program
	Contact your Medicaid Agency for additional details.
Emergency Services An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Emergency services are furnished by a qualified provider to evaluate or stabilize an emergency medical condition. This may include behavioral health emergency room services.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
End-Stage Renal Disease/Dialysis Renal failure (or kidney failure) occurs when the kidneys are not able to perform their normal functions. End stage Renal disease (ESRD) is the term used to describe advanced Renal failure. • Kidney disease education is for members with stage IV chronic kidney disease (CKD) to help delay the need for a kidney transplant or dialysis and prevent kidney disease complications. Kidney disease education teaches members how to take the best possible care of their kidneys and gives them information they need to make informed decisions about their care. • Dialysis services are those provided for the artificial and mechanical removal of toxic materials and the maintenance of fluid, electrolyte, and acid-base balances in cases of impaired or absent kidney function. Dialysis treatments are provided in various	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
settings, including hospital inpatient, hospital outpatient, independent Renal dialysis facility, or the home. • Dialysis home support services and self-dialysis training may be included if the Member is a candidate for home dialysis.	
Experimental, Investigational, Clinical Trials A drug, device or service that has not been approved as safe and effective for general use by the Food and Drug Administration or other governing body.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Enhanced Disease Management Enhanced Disease Management, provided as a part of the case management process, teams up qualifying members with specially-trained case managers. The case managers have detailed knowledge about the member's specific disease and work closely with the member to provide additional educational, clinical and monitoring services.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Family Planning Family planning services include counseling, information, education and communication activities, and delivery of contraceptives/birth control.	Covered by Medicaid Fertility services and drugs prescribed to promote fertility are not covered. Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Gastric Bypass/Obesity Surgery/Bariatrics Bariatrics is a branch of medicine dealing with prevention, control, and treatment of obesity. Gastric bypass/obesity surgery is surgery on the stomach and/or intestines to help the patient with extreme obesity lose weight.	Covered by Medicaid Obesity surgery is covered when medically necessary. Contact your Medicaid Agency for additional details.
Genetic Testing Genetic testing services evaluate the possibility of a genetic disorder, diagnose such disorders, counsel members regarding such disorders, and follow members with known or suspected disorders.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Healthcare Professional Services (Including PCP, Physician, Specialist, and Nurse) Services performed by licensed professionals, including physicians, nurse practitioners, nurse midwives, clinical nurse specialists, and other professionals as licensed by the state. Physicians may include primary care physicians (PCP) and specialists. Services include, but are not limited to surgery, consultation, diagnostic testing, and home, office, institutional, and telehealth visits, and urgently needed services/urgent care.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Other Physician services including services provided in an office setting, clinic, a facility, or in the home. This includes nurse practitioners and physician assistants acting as "physician extenders" are excluded from the capitation and must bill Fee-for-Service. Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Hearing Services Outpatient diagnostic hearing and balance evaluations performed by a physician, audiologist, or other qualified provider to determine if member needs medical treatment. • Audiology is the branch of science that studies hearing, balance, and their disorders. Its practitioners, who study hearing and treat those with hearing losses, are audiologists. Employing various testing strategies (e.g. hearing tests, optoacoustic emission measurements, and electrophysiologic tests), audiology aims to determine whether someone can hear within the normal range, and if not, which portions of hearing (high, middle, or low frequencies) are affected and to what degree. If an audiologist diagnoses a hearing loss he or she will provide recommendations to a patient as to what options (e.g. hearing aids, cochlear implants, surgery, appropriate medical referrals) may be of assistance. • Hearing aid is an apparatus/electronic device that amplifies sound for persons with impaired hearing. The device consists of a microphone, a battery power supply, an amplifier, and a receiver.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Healthy Meals Meals delivered in a home and/or allowed in a congregate setting to provide nutritional support needed to prevent or treat a health related issue and to avoid emergency and healthcare utilization. There are Medicare Supplemental Benefits that may also be available such as Healthy Meals.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Health Homes Health Homes is a care management service model where all of the professionals involved in a members care communicate with one another so that the members medical and behavioral	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program

Benefit Category	New York State Medicaid Program
health and social service needs are addressed in a comprehensive manner. The coordination of a members care is done through a dedicated care manager who oversees and coordinates access to all of the services a member requires in order to facilitate optimum member health status. Federal core Health Home services include: • Comprehensive care management; • Care coordination; • Health promotion; • Comprehensive transitional care/follow-up; • Member and family support; and • Referral to community and social support services.	Health homes case management services for all members are limited to one service per month. Contact your Medicaid Agency for additional details.
Home Health Care Home health services include skilled and non-skilled services, medication administration, and medication management. • Skilled services include skilled nurse services, PT/OT/RT/ST, dieticians and social workers that are provided to eligible members at their place of residence. • Non-skilled services may or may not be under the supervision of a home health or social service agency, but for Medicare purposes must be under the supervision of a registered nurse, and must be reasonable and necessary to the treatment of the patient's illness or injury. The reason for the visits by the home health aide must be to provide hands-on care of the member or services needed to maintain the member's health or to facilitate treatment of the member's illness or injury. • Medication administration is assistance with self administration of medications, whether in the home or	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Allergy injections are not a covered home health service. Services or supplies received from a nurse which do not require the skill and training of a nurse are not covered. Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
a facility. Includes taking the medication for where it is stored and delivering it to the member, removing a prescribed amount of medication from the container and placing it in the member's hand or in another container, helping the member by lifting the container to their mouth, applying topical medications, and keeping a record of when a member receives assistance with self-administration of their medications. • Medication management is review by a licensed nurse of all prescriptions and over the counter medications taken by the member, in conjunction with the member's physician. The purpose of the review is to assess whether the member's medication is accurate, valid non-duplicative and correct for the diagnosis, that therapeutic doses and administration are at an optimum level, that there is appropriate laboratory monitoring and follow up taking place, and that drug interactions, allergies and contraindications are being assessed and prevented.	
Hospice Care Hospice care or palliative care is any form of medical care or treatment that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and supporting the partner and family. Hospice care is multidisciplinary and includes home visits, professional medical help available on call, teaching and emotional support of the family, and physical care of the client. Some hospice programs provide care in a center, as well as in the home.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Long Term Services and Support (LTSS) - Adult Companion Services Adult companion services are non-medical care services, which provide supervision and socialization to functionally impaired adults. These are in-home services to ensure the safety and well-being of members who cannot be left alone. The provision of companion services does not entail hands-on nursing care.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Day Care Services Adult day care provides social activities, meals, recreation, and some health-related services. Alzheimer's specific adult day care provides social and health services only to persons with Alzheimers or related dementia. Day health services offers more intensive health, therapeutic, and social services for individuals with severe medical problems and for those at risk of nursing home care.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Members must have an order from a physician for ADHC or AIDS ADHC services to be assessed for participation in these programs. Adult day health services are not covered for residents of a residential health care facility, homebound members, or members who require continuous inpatient care. Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Assisted Living/Residential Care Assisted living or residential care refers to a system of housing and limited care designed for members who need some assistance with day-to-day activities but are not sufficiently incapacitated to require care in a nursing home.	Covered by Medicaid Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
This service usually includes private quarters, meals, personal assistance, housekeeping aid, monitoring of medications, and nurses' visits. May also include OT, PT and ST.	
Long Term Services and Support (LTSS) - Attendant Care/Personal Care Attendant care/personal care services are services provided by a trained attendant and include mainly activities of daily living (ADLs) and instrumental activities of daily living (IADLs). ADLs include services such as bathing, grooming, and dressing. IADLs include activities such as meal preparation, laundry, light housekeeping, and routine household care.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Community Transition Services Community transition services are services intended to assist individuals in transitioning out of non-acute care institutional settings back to their own home in the community through coverage of one-time transitional expenses. Services generally include the cost of moving furniture and belongings, security deposits to obtain a lease, purchase of furnishings and initial supplies (such as bed, table, chairs, window coverings, household products, dishes, eating utensils, etc.), utility connection fees or deposits, and health and safety assurances (such as pest removal, allergen control, or one-time cleaning prior to occupancy). Community transition services do not include monthly rental or mortgage expense, food, regular utility charges, and/or household appliances, or items that are intended for purely diversional or recreational purposes.	Covered by Medicaid Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Long Term Services and Support (LTSS) - Family Training Training and counseling services for the families of members, including instruction and updates about treatment regimens and use of equipment specified in the plan to safely maintain the member at home. "Family" is defined as individuals who live with or provide care to the member, and may include a parent, spouse, children, relatives, foster family, or in-laws.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Habilitation Acquisition, maintenance and enhancement of skills necessary for the individual to accomplish ADLs and IADLs and health-related tasks. PAS may be a component of Habilitation. However, habilitation can involve but is not limited to training, mobility, money management, management of caregivers, personal decision making, etc.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Healthy Meals Post Discharge and or Chronic Conditions Meals delivered in a home and/or allowed in a congregate setting to provide nutritional support needed to prevent or treat a health related issue and to avoid emergency and healthcare utilization. There are Medicare Supplemental Benefits that may also be available such as: Healthy Meals Post Discharge, Healthy Meals Chronic Conditions	Covered by Medicaid Contact your Medicaid Agency for additional details.
Immunizations/Vaccinations Immunization - The process of becoming immune or the process of rendering a patient immune. Vaccination - The administration, usually by injection, of immunogens as a means of protecting individuals from	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Immunizations solely for foreign travel are not covered.

Benefit Category	New York State Medicaid Program
developing specific diseases; included, but not limited to hepatitis B, influenza, pneumococcal pneumonia and anthrax.	Contact your Medicaid Agency for additional details.
Infertility Services Infertility: Not fertile; especially incapable of or unsuccessful in achieving pregnancy over a considerable period of time (as a year) in spite of determined attempts by heterosexual intercourse without contraception (an infertile male with a low sperm count or an infertile female with blocked fallopian tubes); failing to produce or incapable of producing offspring. Diagnostic techniques may include history and physical, laboratory testing including FSH and Luteinizing hormone levels and sperm count, hysterosalpingogram (HSG), and hysteroscopy. Treatment of infertility can include ovulation induction, ovarian drilling, various fertility drugs such as Clomid, intrauterine insemination and in vitro fertilization.	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Fertility drugs are limited to 3 cycles of treatment per lifetime. Contact your Medicaid Agency for additional details.
Inpatient Hospital Acute An acute medical facility is a hospital that treats patients in the acute phase of an illness or injury. An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services. Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight. The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more. Inpatient hospital services	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
include bed and board, nursing services, diagnostic or therapeutic services, and medical or surgical services.	
Long Term Services and Support (LTSS) - Homemaker Services Homemaker services are services provided by a trained homemaker and include mainly activities of daily living such as bathing, grooming, dressing, instrumental activities of daily living services (IADLS) and general household activities such as meal preparation, laundry, light housekeeping and routine household care.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Home and Vehicle Modifications Home modifications are those physical adaptations to the home which are medically necessary to avoid institutional placement of the member and enable them to function with greater independence in the home. Home modifications are also known as environmental accessibility adaptations. This category also includes vehicle modifications.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Home and vehicle modifications are restricted to members eligible for CFCO services. Vehicle modifications are limited to $15,000 per calendar year. Exceptions may be considered when medically necessary. Environmental modifications are limited to $15,000 per calendar year. Exceptions may be considered when medically necessary. Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Long Term Services and Support (LTSS) - Nursing Home/Facility Nursing facilities are facilities that meet state licensure standards and provide health-related care and services, prescribed by a physician, to residents who require 24-hour-a-day, seven-day-a-week, licensed nursing supervision for ongoing observation, treatment, or care for long-term illness, disease, or injury. Nursing facilities are considered custodial care and not skilled nursing facilities. Refer to category SNFS for skilled nursing facilities.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Pest Control Extermination of household pests (i.e. bugs, rodents, etc.) for maintenance of a clean, sanitary, and safe home.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Long Term Services and Support (LTSS) - Chore Services Non-medical services to maintain the home as a clean, sanitary and safe living environment. These services include heavy household chores above and beyond simple housekeeping.	Covered by Medicaid Contact your Medicaid Agency for additional details.
Medical Supplies Medical supplies are generally disposable or consumable items designed for use by a single individual.	Covered by Medicaid Convenience items are excluded - Vitamins are not covered except when necessary to treat a diagnosed illness or condition Experimental investigational drugs are generally excluded, except

Benefit Category	New York State Medicaid Program
	where approved in the course of experimental/investigational treatment Drugs prescribed for cosmetic purposes are excluded Over-the-counter items are not covered with the exception of diabetic supplies, including insulin, and smoking cessation agents Non-prescription (OTC) drugs and medical supplies are not covered Contact your Medicaid Agency for additional details.
Personal Emergency Response System A personal emergency response system (PERS) consists of a base unit connected to power and a telephone line and a waterproof button worn on a neck pendant or wrist band. If the member falls or needs other assistance and is unable to reach the telephone to call for help, he or she presses the button. This activates the base unit which automatically calls the vendors 24-hour call center.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Podiatry Podiatry is the diagnosis, treatment, and prevention of conditions of the human feet.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Routine hygienic care of the feet, the treatment of corns and calluses, the trimming of nails, and other hygienic care such as cleaning or soaking feet, is not covered in the absence of a pathological condition.

Benefit Category	New York State Medicaid Program
	Pathological conditions are identified by specific diagnosis codes billed in conjunction with specific procedure codes approved by NY Medicaid. Contact your Medicaid Agency for additional details.
Private Duty Nursing Private-duty nurses or private-duty attendants are registered nurses, licensed practical nurses, or any other trained attendant whose services ordinarily are rendered to, and restricted to, a particular patient by arrangement between the patient and the private-duty nurse or attendant.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Private duty nursing services are covered only when determined by the attending physician to be medically necessary. Contact your Medicaid Agency for additional details.
Preventive Services Routine health care that includes check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Prosthetics/Orthotics These are medical devices (other than dental) ordered by your doctor or other health care provider 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	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Limitations are defined by specific types of service received.

Benefit Category	New York State Medicaid Program
malfunctioning internal body organ, including replacement or repairs of such devices. • Orthotics: A support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body. Shoe inserts are orthotics that are intended to correct an abnormal, or irregular walking pattern, by altering slightly the angles at which the foot strikes a walking or running surface. Other orthotics includes neck braces, lumbosacral supports, knee braces, and wrist supports. • Prosthetics: Prosthetic devices are artificial devices or appliances that replace all or part of a permanently inoperative or missing body part.	Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor. Orthotics primarily used for athletic or recreational purpose - mechanical organ Replacement devices including, but not limited to artificial heart. Contact your Medicaid Agency for additional details.
Respite Services provided on a short term basis to members unable to care for themselves due to the absence or need for relief of persons normally providing their care. Respite care does not substitute for the care usually provided by a registered nurse, LPN, or therapist.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Rehabilitative Services for Medical Conditions - Short Term (OT, PT, RT, ST) Performed in home or outpatient setting: • Occupational Therapy (OT) - Based on engagement in meaningful activities of daily life (as self-care skills, education, work, or social interaction) especially to enable or encourage participation in such activities despite impairments or limitations in physical or mental functioning. • Physical Therapy (PT) - The treatment of disease by physical and mechanical means (as massage, regulated exercise, water, light, heat, and electricity) --	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
also called physiotherapy. It is a branch of treatment that uses physical means to relieve pain, regain range of movement, restore muscle strength, and return patients to normal activities of daily living. • Respiratory Therapy (RT) - Assessment and therapeutic treatment of respiratory diseases. May include but not limited to airway management, mechanical ventilation, blood acid/base balance, and critical care medicine. • Pulmonary rehabilitation is designed for people who have chronic lung disease; the primary goal is to achieve and maintain the maximum level of independence and functioning. Although most pulmonary rehabilitation programs focus on the needs of people who have chronic obstructive pulmonary disease, people with other types of lung disease may benefit as well. • Speech Therapy (ST) - Rehabilitative or corrective treatment of physical and/or cognitive deficits/disorders resulting in difficulty with communication and/or swallowing. • Hyperbaric oxygen (HBO) therapy is a modality in which the entire body is exposed to oxygen under increased atmospheric pressure. Hyperbaric oxygenation has been used to treat carbon monoxide poisoning, air embolism, smoke inhalation, acute cyanide poisoning, decompression sickness, clostridial myonecrosis, and certain cases of blood loss or anemia where increased oxygen transport may compensate in part for the hemoglobin deficiency.	
Self-Referral Services Services rendered to a member without requiring a referral by the PCP or MCO, when the enrollee accesses the service through a provider other than the member's PCP.	Covered by Medicaid Not covered by the Health and Recovery Plan (HARP) program

Benefit Category	New York State Medicaid Program
	Contact your Medicaid Agency for additional details.
Skilled Nursing Facility (SNF) A facility (which meets specific regulatory certification requirements) which primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services but does not provide the level of care or treatment available in a hospital. Skilled nursing services or skilled rehabilitation services (or a combination of these services) must be needed and provided on a daily basis, i.e., on essentially a seven days a week basis. A patient whose inpatient stay is based solely on the need for skilled rehabilitation services would meet the daily basis requirement when they need and receive those services on at least five days a week.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Targeted Case Management Services The purpose of the case management program is to provide a coordinated comprehensive program to ensure that members receive efficient/cost effective services at the appropriate level of care through the development of individualized, innovative programs and coordination with community services. The program assesses plans, implements, coordinates, monitors and evaluates options and services to meet the individuals overall healthcare needs through communication and utilization of available resources to promote quality, cost-effective outcomes.	Covered by Medicaid Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Transgender Related Care and Services Gender dysphoria is the diagnosis given to persons whose gender assigned at birth does not match the gender with which they identify, and who experience clinically significant distress as a result. Gender dysphoria may be manifested by a strong desire to be treated as the other gender or to be rid of ones sex characteristics, or by a strong conviction that one has feelings and reactions typical of the other gender. Treatments for gender dysphoria include counseling, hormone therapy, and gender reassignment surgery. Gender reassignment surgery (GRS) is a term for the surgical procedures by which the physical appearance and function of a persons existing sexual characteristics are altered to resemble those of the other sex.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Transportation Non-emergency transportation by ambulance is appropriate if it is documented that the members condition is such that other means of transportation could endanger the persons health and that transportation by ambulance is medically required.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.
Transplants An organ transplant is the transplantation of a whole or partial organ from one body to another for the purpose of replacing the recipient's damaged or failing organ with a working one from the donor. Organ donors can be living or deceased (organ donor services are usually not covered).	Not Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

Benefit Category	New York State Medicaid Program
Vision Services for the prevention, diagnosis and treatment of conditions, diseases, and injuries of the eye. • Ophthalmology is the branch of medicine which deals with the diseases and surgery of the visual pathways, including the eye, brain, and areas surrounding the eye, such as the lachrymal system and eyelids. • Optometry is a health care profession concerned with examination, diagnosis, and treatment of the eyes and related structures and with determination and correction of vision problems using lenses and other optical aids. • Routine vision services include visual examination, fitting, dispensing and adjustment of eyeglasses, follow-up examinations, and contact lenses.	Covered by Medicaid Covered by the Health and Recovery Plan (HARP) program Corrective vision surgery is not covered. Contact your Medicaid Agency for additional details.
Video Doctor Visits (LiveHealth Online) Provides access to interact with a board certified physician via live, two-way video on a computer or mobile device (tablet or smartphone) using an application. It is accessed by visiting www.livehealthonline.com. LiveHealth Online is available for use in two different ways: • For conditions such as colds and flu, infections, rashes and allergies, when you cannot get into see your regular doctor, a doctor will be quickly available to see you. • If you need to discuss feelings of depression, stress or anxiousness (mood), you can schedule a future on-line appointment with a psychologist or social worker.	Covered by Medicaid Not covered by the Health and Recovery Plan (HARP) program Contact your Medicaid Agency for additional details.

SECTION 4 Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded.

The chart below lists services and items that aren't covered by our plan under any conditions or are covered by our plan only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan 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 9, Section 6.3 .)

Services not covered by Medicare	Covered only under specific conditions
You are enrolled in a Dual Special Needs Plan. Some services that are not covered under the Original Medicare Program may be covered under any Medicaid Benefits you are entitled to. Your Medicaid coverage is determined by the state in accordance with your aid category. Should you require a service that is not a Medicare covered service, we can help you coordinate your care to identify any Medicaid coverage or resources available to you.	You will also receive the majority of your Medicaid covered services from our plan as described in the benefit charts located in Chapter 4, Section 2.1.
Acupuncture	Available Medicare covers acupuncture for low chronic back pain under certain circumstances. This plan covers additional acupuncture as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must use a provider who participates in our acupuncture network.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body

Services not covered by Medicare	Covered only under specific conditions
	member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	You may be eligible for these services as referenced in the medical benefits chart located in Chapter 4, Section 2.1.
Defective equipment or medical devices covered under warranty.	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.
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community.	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)
Fees charged for care by your immediate relatives or members of your household.	Not covered under any condition.
Full-time nursing care in your home.	You may be eligible for these services as referenced in the medical benefits chart located in Chapter 4, Section 2.1.

Services not covered by Medicare	Covered only under specific conditions
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	You may be eligible for these services as referenced in the medical benefits chart located in Chapter 4, Section 2.1.
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 authorized or paid by a government entity such as Veterans Administration authorized services.	Not covered under any condition.
Items and services required as a result of war.	Not covered under any condition.
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. 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).
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. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must use a provider who participates in our contracted network.
Naturopath services (uses natural or alternative treatments).	Not covered under any condition.
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care. Dental services are excluded from coverage in connection

Services not covered by Medicare	Covered only under specific conditions
	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.
Non-emergency ambulance trips	You may be eligible for these services as referenced in the Medical Benefits Chart located in Chapter 4, Section 2.1.
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.
Over-the-counter purchases	Medicare doesn't cover Over-the-counter purchases. This plan covers over-the-counter purchases as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must utilize the contracted OTC provider, limitations and exclusions may apply.
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.
Prescription drugs you buy outside the U.S.	Not covered under any condition.
Private room in a hospital.	Covered only when medically necessary.
Providers who are prohibited from being covered under the Medicare program for any reason.	Not covered under any condition.

Services not covered by Medicare	Covered only under specific conditions
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition.
Routine chiropractic care including x-rays, physical therapy, nutrients, office visits	Manual manipulation of the spine to correct a subluxation is covered, if medically necessary, when provided by a chiropractor or another qualified provider. Medicare doesn't cover routine chiropractic care. This plan covers routine chiropractic care as a supplemental benefit. To utilize this benefit, you must use a provider who participates in our routine chiropractic provider network.
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 a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must use a provider who participates in our routine dental vendor's network.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, 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 with standard frames (or one set of contact lenses) covered after each 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, 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

Services not covered by Medicare	Covered only under specific conditions
	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 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 vendor's network or your services will be considered out-of-network, even if rendered by a medical provider who is not part of the vendor's network.
Routine foot care	Some limited coverage provided according to Medicare guidelines, (e.g., if you have diabetes). Medicare covers podiatrist services for medically necessary treatment of foot injuries or diseases (like hammer toes, bunion deformities, and heel spurs), but generally doesn't cover routine foot care (like the cutting or removal of corns and calluses, the trimming, cutting, and clipping of nails, flat foot, or hygienic or other preventive maintenance, including cleaning and soaking the feet). This plan covers additional routine foot care as a supplemental benefit. To utilize this benefit, you must use a provider who participates in our routine podiatry provider network.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	Medicare doesn't cover routine hearing exams, hearing aids, or exams for fitting hearing aids. This plan covers routine hearing care as a supplemental benefit. In addition, supplemental benefit hearing aids

Services not covered by Medicare	Covered only under specific conditions
	are limited to the list of covered devices and custom or alternative devices are not covered. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must use a provider who participates in our routine hearing vendor's network.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition.
Services ordered or administered that are determined to not be a Medicare covered benefit in accordance with Medicare guidelines and the Social Security Act.	Not covered under any condition.
Services performed by non-participating vendor network providers.	Some supplemental benefits utilize a specific vendor and providers who participate with our plan. Providers that participate with the plan may or may not be associated with that vendor. You may call the plan prior to services being rendered with any questions. To be covered in-network, you must use a provider that participates with that vendor as identified in the provider directory. There may be other exceptions, see Chapter 3 (Using the plan for your medical services) for more information.
Services performed by 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 for services not considered urgent/emergent (required immediately) or approved in advance may

Services not covered by Medicare	Covered only under specific conditions
	not be covered by the plan. Go to Chapter 3, Section 2.4 for more information.
Transportation (that Medicare does not cover such as trips to a physician's office) regardless of the member's condition.	Medicare doesn't cover this service. This is considered excluded by statute or a benefit exclusion that is not covered under the Original Medicare program. This plan covers Transportation as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this plan. To utilize this benefit, you must use a provider who participates in our contracted transportation vendor's network.
Wigs (even if needed due to a covered medical condition).	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. as a supplemental benefit. Any supplemental benefit offered is not covered under the Original Medicare program but as extra benefits under this 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 territories.

CHAPTER 5:

Using plan coverage for Part D drugs

How can you get information about your drug costs?

Because you're eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you're in the Extra Help program, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Customer Service at 1-877-269-5706 (TTY users call 711) and ask for the *LIS Rider*. (Phone numbers for Customer Service are printed on the back cover of this document.)

SECTION 1 Basic rules for our plan's Part D drug coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. Our Drug List tells you how to find out about your Medicaid drug coverage.

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription (Go to Section 2 *or you can fill your prescription through our plan's mail-order service.*)
- Your drug must be on our plan's Drug List (Go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that's either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information)

SECTION 2 Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.4 for information about when we cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider/Pharmacy Directory*, visit our website (www.anthem.com), and/or call Customer Service at 1-877-269-5706 (TTY users call 711).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Customer Service at 1-877-269-5706 (TTY users call 711) or use the *Provider/Pharmacy Directory*. You can also find information on our website at www.anthem.com.

Specialized pharmacies

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

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

  If you need help finding a home infusion pharmacy provider in your area, please call Customer Service at the number listed on your membership card, or visit our website to access our online, searchable directory. If you would like a *Provider/Pharmacy Directory* mailed to you, you may call Customer Service, or request one at our website.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting your Part D drugs in an LTC facility, call Customer Service at 1-877-269-5706 (TTY users call 711). Please refer

to your *Provider/Pharmacy Directory* to find out if your long-term-care pharmacy is part of our network.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. Please refer to your *Provider/Pharmacy Directory* to find an I/T/U pharmacy in your area. For more information, contact Customer Service.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your Provider/Pharmacy Directory www.anthem.com or call Customer Service at 1-877-269-5706 (TTY users call 711).

Section 2.2 Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail order are drugs you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **mail-order drugs** in our Drug List.

Our plan's mail-order service allows you to order ***at least* a *30*-day supply of the drug and *no more than* a *90* or *100*-day supply.**

To get order forms and information about filling your prescriptions by mail call our mail-order Customer Service at 1-833-203-1735. TTY users should call 711. Hours are 24 hours a day, 7 days a week. Our Interactive Voice Response (IVR) Service is available 24 hours a day, seven days a week.

Usually, a mail-order pharmacy order will be delivered to you in no more than 14 days. Pharmacy processing time will average about two to five business days; however, you should allow additional time for postal service delivery. It is advisable for first-time users of the mail-order pharmacy to have at least a 30-day supply of medication on hand when a mail-order request is placed. If the prescription order has insufficient information, or if we need to contact the prescribing physician, delivery could take longer. If your mail-order shipment is delayed, please call the mail-order pharmacy number provided in the *Provider/Pharmacy Directory*.

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

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

New prescriptions the pharmacy gets directly from your doctor's office.

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

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

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

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

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

If you never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It's important to respond each time you're contacted by the pharmacy, to let them know whether to ship, delay, or cancel the new prescription.

Refills on mail-order prescriptions. For refills of your drugs, you have the option to sign up for an automatic refill program. Under this program we start to process your next refill automatically when our records show you should be close to running out of your drug. The pharmacy will contact you before shipping each refill to make sure you need more medication, and you can cancel scheduled refills if you have enough medication or your medication has changed.

If you choose not to use our auto-refill program but still want the mail-order pharmacy to send you your prescription, contact your pharmacy 30 days before your current prescription will run out. This will ensure your order is shipped to you in time.

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

If you get a refill automatically by mail that you don't want, you may be eligible for a refund.

Section 2.3 How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.)

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* www.anthem.com tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service at 1-877-269-5706 (TTY users call 711) for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.2 for more information.

Section 2.4 Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Customer Service at 1-877-269-5706 (TTY users call 711)** to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

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

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

SECTION 3 Your drugs need to be on our plan's Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List.**

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare.

The Drug List only shows drugs covered under Medicare Part D. In addition to the drugs covered by Medicare, some prescription drugs are covered under your Medicaid benefits. The Drug List tells you how to find out about your Medicaid drug coverage.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or

- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren’t on the Drug List

Our plan doesn’t cover all prescription drugs.

- In some cases, the law doesn’t allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that isn’t on our Drug List. (For more information, go to Chapter 9.)
- The Drug List does not include prescription drugs that are only covered by Medicaid. Please contact your state Medicaid agency for information about prescription drugs covered by Medicaid.

Section 3.2 *There are Six cost-sharing tiers for drugs on the Drug List*

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

- **Tier 1** includes preferred generic drugs.
- **Tier 2** includes generic drugs. It may also include some brand-name drugs.
- **Tier 3** includes preferred brand-name drugs.
- **Tier 4** includes non-preferred drugs.
- **Tier 5** includes specialty drugs. Drugs in this cost-sharing tier generally cost you more than drugs in the other cost-sharing tiers.
- **Tier 6** includes select care drugs for diabetic, blood pressure, cholesterol conditions and osteoporosis.

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (www.anthem.com). The Drug List on the website is always the most current.
- Call Customer Service at 1-877-269-5706 (TTY users call 711) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (www.anthem.com) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Customer Service at 1-877-269-5706 (TTY users call 711). Within your secure online account at www.anthem.com, select Prescriptions – Price a Medication and type the prescription name in the search.

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once in our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Customer Service at 1-877-269-5706 (TTY users call 711) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Customer Service at 1-877-269-5706 (TTY users call 711) or on our website www.anthem.com.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition and Drug A is less costly, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.** Our plan's step therapy criteria can be obtained by calling Customer Service at 1-877-269-5706 (TTY users call 711) or on our website www.anthem.com.

Quantity limits

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

SECTION 5 What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take, isn't on our Drug List or has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on our plan's Drug List** OR **is now restricted in some way.**

- **If you're a new member,** we'll cover a temporary supply of your drug during the first ***90 days*** of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first ***90 days*** of the calendar year.
- This temporary supply will be for a maximum of 30 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 30 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 34-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Customer Service at 1-877-269-5706 (TTY users call 711).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Customer Service at 1-877-269-5706 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it's not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 What to do if your drug is in a cost-sharing tier you think is too high

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Customer Service at 1-877-269-5706 (TTY users call 711) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 7.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Drugs in our **Tier 5** - Specialty Tier aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

SECTION 6 Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand name drug with a generic version of the drug.**
- **Replace an original biological product with an interchangeable biosimilar version of the biological product.**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes were made for a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
    - We may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
    - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
    - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
    - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.

- We'll make these changes only if we add a new generic version of a brand name drug or adding certain new biosimilar versions of an original biological product that was already on the Drug List.
- We'll tell you at least 30 days before we make the change or tell you about the change and cover an 30-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you're taking that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you take.

If we make any of these changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or ask for a coverage decision to satisfy any new restrictions on the drug you're taking. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you have been taking. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won’t tell you about these types of changes directly during the current plan year. You’ll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

SECTION 7 Types of drugs we don’t cover

Some kinds of prescription drugs are *excluded*. This means Medicare doesn't pay for these drugs.

If you appeal and the drug asked for is found not to be excluded under Part D, we’ll pay for or cover it. (For information about appealing a decision, go to Chapter 9.) If the drug excluded by our plan is also excluded by Medicaid, you must pay for it yourself

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan’s Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug’s label as approved by the FDA.

In addition, by law, the following categories of drugs listed below aren’t covered by Medicare or Medicaid.

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program

to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for our share of the costs of your drug. You'll need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If your prescription is not covered under the plan, you may have coverage under your Medicaid benefits. Please provide the pharmacy with your Medicaid card to fill prescriptions not covered under the Medicare Part D prescription drug benefit.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

SECTION 9 Part D drug coverage in special situations

Section 9.1 In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all of our rules for coverage described in this chapter.

Section 9.2 As a resident in a long-term care (LTC) facility

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

Check your *Provider/Pharmacy Directory* www.anthem.com to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Customer Service at 1-877-269-5706 (TTY users call 711). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that isn't on our Drug List or restricted in some way, go to Section 5.1 for information about getting a temporary or emergency supply.

Section 9.3 If you're in Medicare-certified hospice

Hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

SECTION 10 Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

Section 10.1 Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s)
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an

MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up to date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Customer Service at 1-877-269-5706 (TTY users call 711).

CHAPTER 6:

What you pay for Part D drugs

SECTION 1 What you pay for Part D drugs

We use “drug” in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are excluded from Part D coverage by law. Some of the drugs excluded from Part D coverage are covered under Medicare Part A or Part B or under Medicaid.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan’s “Real-Time Benefit Tool” to look up drug coverage (www.anthem.com), the cost you see shows an estimate of the out-of-pocket costs you’re expected to pay. You can also get information provided in the “Real-Time Benefit Tool” by calling Customer Service at 1-877-269-5706 (TTY users call 711).

How can you get information about your drug costs?

Because you’re eligible for Medicaid, you qualify for and are getting Extra Help from Medicare to pay for your prescription drug plan costs. Because you have Extra Help, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don’t have this insert, call Customer Service at 1-877-269-5706 (TTY users call 711) and ask for the *LIS Rider*.

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

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.2 How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they're for covered Part D drugs and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the following drug payment stages:
  - The Deductible Stage
  - The Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, State Pharmaceutical Assistance Programs (SPAPs), and most charities

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2,100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments <u>aren't included</u> in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments you make toward drugs not normally covered in a Medicare Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)

- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Customer Service at 1-877-269-5706 (TTY users call 711).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2,100, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) members

There are **3 drug payment stages** for your drug coverage under Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP). How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

- **Stage 1: Yearly Deductible Stage**
- **Stage 2: Initial Coverage Stage**
- **Stage 3: Catastrophic Coverage Stage**

SECTION 3 Your *Part D Explanation of Benefits* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health

Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower cost alternative prescriptions.** This shows information about other available drugs with lower cost sharing for each prescription claim, if applicable

Section 3.1 Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled**. This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won’t automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts:**
    - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that’s not part of our plan’s benefit.
    - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
    - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
    - If you’re billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or have questions, call Customer Service at 1-877-269-5706 (TTY users call 711). Be sure to keep these reports.

SECTION 4 The Deductible Stage

Because most of our members get Extra Help with their prescription drug costs, the Deductible Stage doesn’t apply to most members. If you get Extra Help, this payment stage doesn’t apply to you.

Look at the separate insert (the *LIS Rider*) for information about your deductible amount.

If you don’t get Extra Help, the Deductible Stage is the first payment stage for your drug coverage. The deductible doesn’t apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. You'll pay a yearly deductible of $615 on **Tier** 2: Generic, **Tier** 3: Preferred Brand, **Tier** 4: Non-Preferred Drug, and **Tier** 5: Specialty Tier. **You must pay the full cost of your Tier 2: Generic, Tier 3: Preferred Brand, Tier 4: Non-Preferred Drug, and Tier 5: Specialty Tier drugs** until you reach our plan’s deductible amount. For all other drugs, you won't have to pay any deductible. The **full cost** is usually lower than the normal full price of the drug since our plan negotiated lower costs for most drugs at network pharmacies. The full cost cannot exceed the maximum fair price plus dispensing fees for drugs with negotiated prices under the Medicare Drug Price Negotiation Program.

Once you pay $615 for your **Tier** 2: Generic, **Tier** 3: Preferred Brand, **Tier** 4: Non-Preferred Drug, and **Tier** 5: Specialty Tier drugs, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription

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

Our plan has six cost-sharing tiers

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

- **Tier 1** includes preferred generic drugs.
- **Tier 2** includes generic drugs. It may also include some brand-name drugs.
- **Tier 3** includes preferred brand-name drugs. **If you receive Extra Help,** you pay $0.00 - $12.65 per month supply of each covered insulin product on this tier. **If you do <u>not</u> qualify for Extra Help,** you won't pay more than $35.00 per month supply of each covered insulin product on this tier.
- **Tier 4** includes non-preferred drugs.
- **Tier 5** includes specialty drugs. Drugs in this cost-sharing tier generally cost you more than drugs in the other cost-sharing tiers.
- **Tier 6** includes select care drugs for diabetic, blood pressure, cholesterol conditions and osteoporosis.

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

Your pharmacy choices

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

- A network retail pharmacy
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Provider/Pharmacy Directory* www.anthem.com.

Section 5.2 Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	Standard retail in-network cost sharing (up to a 30-day supply)	Mail-order cost sharing (up to a 30-day supply)	Long-term care (LTC) cost sharing (up to a 34-day supply)	Out-of-network cost sharing (Coverage is limited to certain situations; go to Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred Generic)	$0.00			
Cost-Sharing Tier 2 (Generic)	$0.00 - $12.65 OR 25%*			
Cost-Sharing Tier 3 (Preferred Brand)	$0.00 - $12.65 OR 25%*			
Cost-Sharing Tier 4 (Non-Preferred Drug)	$0.00 - $12.65 OR 25%*			
Cost-Sharing Tier 5 (Specialty Tier)	$0.00 - $12.65 OR 25%*			
Cost-Sharing Tier 6 (Select Care Drugs)	$0.00			

*If you receive Extra Help, the amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage and whether you use a generic or brand drug. Please refer to your *LIS Rider* for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.

Insulin Cost Sharing:

If you receive Extra Help, you pay $0.00 - $12.65 for Tier 3 for a one-month supply of each covered insulin product.

If you do not qualify for Extra Help, you won't pay more than $35.00 for Tier 3 for a one-month supply of each covered insulin product, even if you haven't paid your deductible.

Go to Section 7 for more information on cost sharing for Part D vaccines.

Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 Your costs for a *long-term* (up to a 90 or 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 90 or 100-day supply.

Your costs for a long-term (up to a 90 or 100-day) supply of a covered Part D drug

Tier	Standard retail cost sharing (in-network)	Mail-order cost sharing
Cost-Sharing Tier 1 (Preferred Generic) up to a 90-day supply	$0.00	
Cost-Sharing Tier 2 (Generic) up to a 90-day supply	$0.00 - $12.65 OR 25%*	
Cost-Sharing Tier 3 (Preferred Brand) up to a 90-day supply	$0.00 - $12.65 OR 25%*	
Cost-Sharing Tier 4	$0.00 - $12.65 OR 25%*	

Tier	Standard retail cost sharing (in-network)	Mail-order cost sharing
(Non-Preferred Drug) up to a 90-day supply		
Cost-Sharing Tier 5 (Specialty Tier)	A long-term supply is not available for drugs in Tier 5.	
Cost-Sharing Tier 6 (Select Care Drugs) up to a 100-day supply	$0.00	

*If you receive Extra Help, the amount you pay is determined by your Extra Help low-income subsidy (LIS) coverage and whether you use a generic or brand drug. Please refer to your *LIS Rider* for your specific copayment amount. If you do not qualify for Extra Help, you pay the coinsurance.

Insulin Cost Sharing:

If you receive Extra Help, you will pay $0.00 - $12.65 for Tier 3 for a 2 or 3 month supply of each covered insulin product.

If you do not qualify for Extra Help, you won't pay more than $70.00 for Tier 3 for a 2-month supply and $105.00 for Tier 3 for a 3-month supply of each covered insulin product, even if you haven't paid your deductible.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $2,100. You then move to the Catastrophic Coverage Stage.

The *Part D EOB* that you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the $2,100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2,100 limit for the calendar

year. Once you're in the Catastrophic Coverage Stage, you stay in this payment stage until the end of the calendar year.

- During this payment stage, you pay nothing for your covered Part D drugs.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you even if you haven't paid your deductible. Go to our plan's Drug List or call Customer Service at 1-877-269-5706 (TTY users call 711) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

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

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
    - Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
    - The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
    - A pharmacist or another provider may give the vaccine in the pharmacy. Or, a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

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

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine (including administration), and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

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

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your coinsurance or copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any coinsurance or copayment for the vaccine administration, and less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we'll reimburse you for this difference.)

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

CHAPTER 7:

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

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

Our network providers bill our plan directly for your covered services and drugs. If you get a bill for the full cost of medical care or drugs you got, send this bill to us so that we can pay it. When you send us the bill, we'll look at the bill and decide whether the services and drugs should be covered. If we decide they should be covered, we'll pay the provider directly.

If you already paid for a Medicare service or item covered by our plan, you can ask our plan to pay you back (paying you back is often called **reimburse** you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter. When you send us a bill you've already paid, we'll look at the bill and decide whether the services or drugs should be covered. If we decide they should be covered, we'll pay you back for the services or drugs.

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

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

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**
    - You can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases, ask the provider to bill our plan.
    - If you pay the entire amount yourself at the time you get the care, ask us to pay you back. Send us the bill, along with documentation of any payments you made.

- You may get a bill from the provider asking for payment that you think you don't owe. Send us this bill, along with documentation of any payments you made.
    - If the provider is owed anything, we'll pay the provider directly.
    - If you already paid for the service, we'll pay you back.

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

Network providers should always bill our plan directly. But sometimes they make mistakes and ask you to pay for your services.

- Whenever you get a bill from a network provider send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, send us the bill along with documentation of any payment you made. Ask us to pay you back for your covered services.

3. If you're retroactively enrolled in our plan

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

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

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

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out-of-network pharmacies in limited circumstances. Go to Chapter 5, Section 2.4 to learn more about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount that we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost of the drug. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

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

You can ask 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've 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 got the service, item, or drug.

To make sure you're 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'll 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).
- Download a copy of the form from our website www.anthem.com or call Customer Service at 1-877-269-5706 (TTY users call 711) 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 1407 Church Street Station
New York, NY 10008-1407

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

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

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

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost for the service or drug. If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost of the care or drug. We'll send you a letter explaining the reasons why we aren't sending the payment and your rights to appeal that decision.

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

CHAPTER 8:

Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. This document is available for free in Spanish. We can also give you materials in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Customer Service at 1-877-269-5706 (TTY users call 711).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Customer Service at 1-877-269-5706 (TTY users call 711) or by writing us at: Civil Rights Coordinator, Mailstop: OH0205-A537; 4361 Irwin Simpson Rd, Mason, OH 45040. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

Debemos brindarle información de manera que le sea útil y coherente con su sensibilidad cultural (en idiomas distintos del inglés, en braille, en letra grande u otros formatos alternativos, etc.).

Su plan debe garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de una manera que sea culturalmente competente y estén disponibles para todos los inscritos, incluidos aquellos con un dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con antecedentes culturales y étnicos diversos. Los ejemplos de cómo un plan puede cumplir con estos requisitos de accesibilidad incluyen, entre otros, la provisión de servicios de traducción, servicios de interpretación, teletipos o conexión para TTY (teléfono de texto o teletipo).

Nuestro plan cuenta con servicios gratuitos de interpretación para contestarles preguntas a los miembros que no hablen inglés. También podemos brindarle información en braille, en letra grande o en otros formatos alternativos, sin costo, en el caso de que lo necesite. Nosotros debemos brindarle la información sobre los beneficios del plan en un formato que sea comprensible y apropiado para usted. Para que le brindemos información de un modo adecuado para usted, llame a Servicio al cliente.

Nuestro plan debe ofrecerles a las mujeres inscritas la opción de un acceso directo a un especialista en salud de la mujer dentro de la red para los servicios de cuidado de rutina y cuidado médico preventivo.

Si para una especialidad determinada no se encuentran disponibles proveedores dentro de la red del plan, es responsabilidad del plan encontrar proveedores de la especialidad fuera de la red que puedan brindarle el cuidado que necesita. En este caso, usted solo pagará los costos compartidos dentro de la red. Si no encuentra especialistas dentro de la red del plan que cubran un servicio que necesita, llame al plan para obtener información sobre dónde puede dirigirse para obtener este servicio abonando los costos compartidos dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y apropiado para usted, llámenos para presentar un reclamo al 1-877-269-5706; (Los usuarios de TTY deben llamar 711) o escríbanos a Civil Rights Coordinator (Coordinador de Derechos Civiles), Mailstop: OH0205-A537; 4361 Irwin Simpson Rd, Mason, OH 45040. También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente ante la Oficina de Derechos Civiles llamando al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan’s network to provide and arrange for your covered services.

You also have the right to go to a women’s health specialist (such as a gynecologist) without a referral.

You have the right to get appointments and covered services from our plan’s network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 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 Practice*, 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've given legal power to make decisions for you first.*
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
    - We are required to release health information to government agencies that are checking on quality of care.
    - Because you're a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

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

You have the right to know how your health information has been shared with others for any purposes that aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Customer Service at 1-877-269-5706 (TTY users call 711).

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 our plan, our network of providers, and your covered services

As a member of Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Customer Service at *1-877-269-5706* (TTY users call *711*):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies 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. Chapter 5 provides information about Part D drug coverage.
- **Information about why something isn't covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 You have the right to know about your treatment options and participate in decisions about your care

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave.

You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

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

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people**. Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital did not follow the instructions in it, you can file a complaint with the New York Department of Health.

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**. You have the right to make recommendations regarding the organization's member rights and responsibilities policy.

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

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

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

- **Call our plan's Customer Service at 1-877-269-5706 (TTY users call 711)**
- **Call your local SHIP** at 1-800-701-0501
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Customer Service at 1-877-269-5706 (TTY users call 711)**
- **Call your local SHIP** at 1-800-701-0501
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication *Medicare Rights & Protections* (available at: Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Customer Service at *1-877-269-5706* (TTY users call 711).

- **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's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **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 you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you're responsible for these payments:
  - You must continue to pay your Medicare premiums to stay a member of our plan.
  - For most of your drugs covered by our plan, you must pay your share of the cost when you get the drug.
  - If you're required to pay the extra amount for Part D because of your higher income (as reported on your last tax return), you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **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 our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:

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

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

This chapter explains the processes for handling problems and concerns. The process you use to handle your problem depends on the type of problem you're having:

- 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).

Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

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

Section 1.1 Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Customer Service at 1-877-269-5706 (TTY users call 711) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program isn't connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare for help:

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

You can get help and information from New York State Medicaid

You can get help and information from New York State Medicaid.

- You can call the Medicaid Helpline at 1-800-541-2831 (TTY 711) Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM.
- You can write to your Local Department of Social Services (LDSS). Find the address for your LDSS at: www.health.ny.gov/health_care/medicaid/ldss
- You can also visit the New York State Medicaid website: www.health.ny.gov/health_care/medicaid

SECTION 3 Understanding Medicare and Medicaid complaints and appeals

You have Medicare and get help from Medicaid. Information in this chapter applies to **all** your Medicare and Medicaid benefits. This is called an integrated process because it combines, or integrates, Medicare and Medicaid processes.

Sometimes the Medicare and Medicaid processes aren't combined. In those situations, use a Medicare process for a benefit covered by Medicare and a Medicaid process for a benefit covered by Medicaid. These situations are explained in **Section 6.4**.

SECTION 4 Which process to use for your problem

If you have a problem or concern, read the parts of this chapter that apply to your situation. The information below will help you find the right section of this chapter for problems or complaints about **benefits covered by Medicare or Medicaid.**

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 5, A guide to coverage decisions and appeals.**

No.

Go to **Section 11, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

Coverage decisions and appeals

SECTION 5 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your

request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances, a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so, or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 6.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed in Section 7 of this chapter.

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

Section 5.1 Get help asking for a coverage decision or making an appeal

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

- **Call Customer Service at** 1-877-269-5706 (TTY users call 711)
- **Get free help** from your State Health Insurance Assistance Program
- **Your doctor or other health care provider can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Customer

Service at 1-877-269-5706 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.)

- For medical care, your doctor or other health care provider can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it'll be automatically forwarded to Level 2.
- If your doctor or other health provider asks that a service or item that you're already getting be continued during your appeal, you **may** need to name your doctor or other prescriber as your representative to act on your behalf.
- For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.

- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.

If you want a friend, relative, or other person to be your representative, call Customer Service at 1-877-269-5706 (TTY users call 711) and ask for the *Appointment of Representative* form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.) This form gives that person permission to act on your behalf. It must be signed by you and the person you want to act on your behalf. You must give us a copy of the signed form.

We can accept an appeal request from a representative without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.

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

Section 5.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines, we give the details for each of these situations:

- **Section 6:** "Medical care: How to ask for a coverage decision or make an appeal"
- **Section 7:** "Part D drugs: How to ask for a coverage decision or make an appeal"

- **Section 8:** "How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon"
- **Section 9:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Customer Service at 1-877-269-5706 (TTY users call 711). You can also get help or information from your SHIP.

SECTION 6 Medical care: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting coverage for medical care or want us to pay you back for your care

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

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

1. You aren't getting certain medical care you want, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
2. Our plan won't approve the medical care your doctor or other health care provider wants to give you, and you believe our plan covers this care. **Ask for a coverage decision. Section 6.2.**
3. You got medical care that you believe our plan should cover, but we said we won't pay for this care. **Make an appeal. Section 6.3.**
4. You got and paid for medical care that you believe our plan should cover, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 6.5.**
5. You're told that coverage for certain medical care you've been getting (that we previously approved) will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 6.3.**

   Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 8 and 9. Special rules apply to these types of care.

Section 6.2 How to ask for a coverage decision

Legal Terms:

A coverage decision that involves your medical care is called an **organization determination.**

A **fast coverage decision** is called an **expedited determination.**

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, 24 hours for Part B drugs.

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

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

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

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

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request **for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days** after we get your request. If your request is for a **Part B drug,** we'll give you an answer within **72 hours** after we get your request**.**

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll 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. Go to Section 11 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

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

- **However,** if you ask for more time, or if we need more that may benefit you, **we can take up to 14 more calendar days**. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (Go to Section 11 for information on complaints.) We'll call you as soon as we make the decision.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no.

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

- If 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're going on to Level 1 of the appeals process.

Section 6.3 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.**

A fast appeal is also called an **expedited reconsideration.**

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

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 48 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll 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 6.2.

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

- **If you're asking for a standard appeal, submit your standard appeal in writing.** Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a free copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

If we told you we were going to stop or reduce services or items that you were already getting, you may be able to keep those services or items during your appeal.

- If we decided to change or stop coverage for a service or item that you currently get, we'll send you a notice before taking the proposed action.
- If you disagree with the action, you can file a Level 1 appeal. We'll continue covering the service or item if you ask for a Level 1 appeal within 10 calendar days of the postmark date on our letter or by the intended effective date of the action, whichever is later.
- If you meet this deadline, you can keep getting the service or item with no changes while your Level 1 appeal is pending. You'll also keep getting all other services or items (that aren't the subject of your appeal) with no changes.

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

- When we are reviewing your appeal, we take a careful look at all the information. We check to see if we were following all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 48 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
    - If you ask for more time, or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
    - If we don't give you an answer within 48 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage we agreed to within 48 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll 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 gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
    - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
    - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, go to **Section 11**.)
    - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal where an independent review organization will review the appeal. Section 6.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within **30 calendar days**, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal, you have additional appeal rights.**

- If we say no to part or all of what you asked for, we'll send you a letter.
  - If your problem is about coverage of a Medicare service or item, the letter will tell you that we sent your case to the independent review organization for a Level 2 appeal.
  - If your problem is about coverage of a Medicaid service or item, the letter will tell you how to file a Level 2 appeal yourself.

Section 6.4 The Level 2 appeal process

Legal Term

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

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

- If your problem is about a service or item that's usually **covered by Medicare**, we'll automatically send your case to Level 2 of the appeals process as soon as the Level 1 appeal is complete.
- If your problem is about a service or item that's usually **covered by Medicaid**, you can file a Level 2 appeal yourself. The letter will tell you how to do this. Information is also below.
- If your problem is about a service or item that could be **covered by both Medicare and Medicaid**, you'll automatically get a Level 2 appeal with the independent review organization. You can also ask for a Fair Hearing with the state.

If you qualified for continuation of benefits when you filed your Level 1 appeal, your benefits for the service, item, or drug under appeal may also continue during Level 2. Go to page 246 for information about continuing your benefits during Level 1 appeals.

- If your problem is about a service that's usually covered by Medicare only, your benefits for that service will not continue during the Level 2 appeals process with the independent review organization.
- If your problem is about a service that's usually covered by Medicaid, your benefits for that service will continue if you submit a Level 2 appeal within 10 calendar days after getting our plan's decision letter.

If your problem is about a service or item Medicare usually covers:

Step 1: The independent review organization reviews your appeal.

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a free copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.
- Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

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

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

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

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

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

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

- **If the independent review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage **within 72 hours** or provide the service within 14 calendar days after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within **72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**

we have **24 hours** from the date we get the decision from the independent review organization

- **If the independent review organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.
- If your Level 2 appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go to Level 3 and make a third 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 10** in this chapter explains the process for Level 3, 4, and 5 appeals.

If your problem is about a service or item Medicaid usually covers:

Step 1: Ask for a Fair Hearing with the state.

- Level 2 of the appeals process for services usually covered by Medicaid is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or over the phone **within 120 calendar days** of the date that we sent the decision letter on your Level 1 appeal. The letter you get from us will tell you where to submit your hearing request.
- You can ask for a Fair Hearing with the state:
  - By phone: 1-800-342-3334 (TTY call 711 and ask the operator to call 1-877-502-6155)
  - By fax: 518-473-6735
  - By internet: http://otda.ny.gov/oah/FHReq.asp
  - By mail:
    NYS Office of Temporary and Disability Assistance Office of Administrative Hearings Managed Care Hearing Unit
    P.O. Box 22023 Albany, New York 12201-2023
  - In person:

- For non-New York City residents:
  Office of Temporary and Disability Assistance Office of Administrative Hearings
  40 North Pearl Street Albany, New York 12243
- For New York City residents:
  Office of Temporary and Disability Assistance Office of Administrative Hearings
  5 Beaver Street
  New York, New York 10004

After you ask for a Fair Hearing, the State will send you a notice with the time and place of the hearing. At the hearing you will be asked to explain why you think this decision is wrong. A hearing officer will hear from both you and the plan and decide whether our decision was wrong. If the State denies your request for a fast track Fair Hearing, they will call you and send you a letter. If your request for a fast track Fair Hearing is denied, the State will process your Fair Hearing in 90 days. If the State approves your request for a fast track Fair Hearing, they will call you to give you the time and date of your hearing. All Fast Track Fair Hearings will be held by phone. **To prepare for the hearing:**

- **We will send you a copy of the "evidence packet" before the hearing.** This is information we used to make our decision about your services. We will give this information to the hearing officer to explain our decision. If there is not time enough to mail it to you, we will bring a copy of the evidence packet to the hearing for you. If you do not get the evidence packet by the week before your hearing, you can call 1-877-269-5706 to ask for it.
- **You have the right to see your case file and other documents.** Your case file has your health records and may have more information about why your health care service was changed or not approved. You can also ask to see guidelines and any other document we used to make this decision. You can call 1-877-269-5706 to see your case file and other documents, or to ask for a free copy. Copies will only be mailed to you if you say you want them to be mailed.
- **You have a right to bring a person with you to help you at the hearing, like a lawyer, a friend, a relative or someone else.** At the hearing, you or this person can give the hearing officer something in writing, or just say why the decision was wrong. You can also bring people to speak in your favor. You or this person can also ask questions of any other people at the hearing.
- **You have the right to submit documents to support your case.** Bring a copy of any papers you think will help your case, such as doctor's letters, health care bills, and receipts. It may be helpful to bring a copy of this notice and all the pages that came with it to your hearing.
- **You may be able to get legal help by calling your local Legal Aid Society or advocate group.** To locate a lawyer, go to www.LawhelpNY.org. In New York City, call 311.

External Appeal
You have other appeal rights if we said the service you asked for was:

1. not medically necessary;
2. experimental or investigational;
3. not different from care you can get in the plan's network; or
4. available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you can ask New York State (NYS) for an independent External Appeal. This is called an External Appeal because it is decided by reviewers who do not work for Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) or NYS. These reviewers are qualified people approved by NYS. The service must be in the plan's benefit package or be an experimental treatment, clinical trial, or treatment for a rare disease. You do not have to pay for an External Appeal. You have **4 months,** from the date that we sent the decision letter on your Level 1 appeal to ask for an External Appeal. If you and Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) agreed to skip our appeals process, then you must ask for the External Appeal within 4 months of when you made that agreement. To ask for an External Appeal, fill out an application and send it to the Department of Financial Services. You can call Member Services at 1-877-269-5706 if you need help filing an External Appeal. You and your doctors will have to give information about your medical problem. The External Appeal application says what information will be needed. Here are some ways to get an External Appeal application:

- Call the Department of Financial Services at 1-800-400-8882
- Go to the Department of Financial Services' website www.dfs.ny.gov
- Contact us at 1-877-269-5706

Your External Appeal will be decided in 30 days. More time (up to five work days) may be needed if the External Appeal reviewer asks for more information. You and Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) will be told the final decision within two days after the decision is made.

You can get a faster decision if:

- Your doctor says that a delay will cause serious harm to your health; or
- You are in the hospital after an emergency room visit and the hospital care is denied by your plan. This is called an Expedited External Appeal. The External Appeal reviewer will decide an expedited appeal in 72 hours or less. If you asked for inpatient substance use disorder treatment at least 24 hours before you were to leave the hospital, we will continue to pay for your stay if:
    - you ask for a fast track Level 1 appeal within 24 hours, **AND**
    - you ask for a fast track External Appeal at the same time.

We will continue to pay for your stay until there is a decision made on your appeals. We will make a decision about your fast track Level 1 appeal in 24 hours. The fast track External Appeal will be decided in 72 hours. The External Appeal reviewer will tell you and the plan the decision right away by phone or

fax. Later, a letter will be sent that tells you the decision. You may ask for a Fair Hearing or ask for an External Appeal, or both. If you ask for both a Fair Hearing **and** an External Appeal, the decision of the fair hearing officer will be the one that counts.

Step 2: The Fair Hearing office gives you its answer.

The Fair Hearing office will tell you its decision in writing and explain the reasons.

- **If the Fair Hearing office says yes to part or all of a request for a medical item or service,** we must authorize or provide the service or item within 72 hours after we get the decision from the Fair Hearing office.
- **If the Fair Hearing office says no to part or all of your appeal,** they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called **upholding the decision** or **turning down your appeal**.)

If the decision is no for all or part of what you asked for, you can make another appeal.

If the independent review organization or Fair Hearing office decision is no for all or part of what you asked for, you have **additional appeal rights**.

The letter you get from the Fair Hearing office will describe this next appeal option.

Go to **Section 10** for more information on your appeal rights after Level 2.

Section 6.5 If you're asking us to pay you back for a bill you got for medical care

We can't reimburse you directly for a Medicaid service or item. If you get a bill for Medicaid-covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting the service or item.

Asking to be paid back for something you have already paid for

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. We can't reimburse you directly for a **Medicaid** service or item. If you get a bill for Medicaid covered services and items, send the bill to us. **Don't pay the bill yourself.** We'll contact the health care provider directly and take care of the problem. If you do pay the bill, you can get a refund from that health care provider if you followed the rules for getting services or items.

If you want us to reimburse you for a **Medicare** service or item or you're asking us to pay a health care provider for a Medicaid service or item you paid for, ask us to make this coverage decision. We'll check

to see if the medical care you paid for is a covered service. We'll 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 Medicare medical care is covered, we'll send you the payment for the cost within 60 calendar days after we get your request.

If the Medicaid care that you paid a health care provider for is covered and you think we should pay the health care provider instead, we'll send your health care provider the payment for the cost within 60 calendar days after we get your request.

Then you'll need to contact your health care provider to get them to pay you back. If you haven't paid for the medical care, we'll send the payment directly to the health care provider.

- **If we say no to your request:** If the medical care *isn't* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we'll not pay for the medical care and the reasons why.

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

To make this appeal, follow the process for appeals in Section 6.3. For appeals concerning reimbursement, note:

- We must give you our answer within 30 calendar days after we get your appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the health care provider within 60 calendar days.

SECTION 7 Part D drugs: How to ask for a coverage decision or make an appeal

Section 7.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only**. To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D* drug every time. We also use the term Drug List instead *of List of Covered Drugs* or formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term:

An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that isn't on our plan's Drug List. **Ask for an exception. Section 7.2.**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 7.2.**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 7.2.**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 7.4.**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 7.4.**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 7.2 Asking for an exception

Legal Terms:

Asking for coverage of a drug that's not on the Drug List is a **formulary exception.**

Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 3 examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay the cost-sharing amount that applies to drugs in **Tier 4** Non-Preferred Drug. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
2. **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List.If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our "Drug List" is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug.
    - If our "Drug List" contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s).
    - You can't ask us to change the cost-sharing tier for any drug in **Tier 5** - Specialty Tier.
    - If we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount.

Section 7.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons you're asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally **won't** approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request, you can ask for another review by making an appeal.

Section 7.4 How to ask for a coverage decision, including an exception

Legal term:

A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements:**

- You must be asking for a *drug you didn't get yet.* (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we'll automatically give you a fast coverage decision.**

- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
    - Explains that we'll use the standard deadlines.
    - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
    - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request* form or on our plan's form, which are available on our website www.anthem.com. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement,** which is the medical reason for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
    - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
    - If we don't meet this deadline, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must give you our answer **within 72 hours** after we get your request.
    - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
    - If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we get your request.

If we don't meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.

- **If our answer is yes to part or all of what you asked for,** we are also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an 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 drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 7.5 How to make a Level 1 appeal

Legal Terms:

An appeal to our plan about a Part D drug coverage decision is called a **plan redetermination.**

A fast appeal is called an **expedited redetermination.**

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 48 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 7.4.

Step 2: You, your representative, doctor or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request**. Chapter 2 has contact information.
- **For fast appeals, either submit your appeal in writing or call us at** . Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website www.anthem.com. Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we review your appeal, we take another careful look at all the information about your coverage request. We check to see if we were following all the rules when we said no to your request.

- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 48 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
    - If we don't give you an answer within 48 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.5** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage we agreed to within 48 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for,** we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
    - If we don't give you a decision within 7 calendar days, we're required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. **Section 7.5** explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
    - If we don't meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for,** we are also required to make payment to you within 30 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Legal Term

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you'll include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.** We're allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.

- If the independent review organization agrees to give you a fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** after it gets your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it gets your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you have already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for,** we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If the independent organization says no to part or all of your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go 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 10** talks more about the process for Level 3, 4, and 5 appeals.

SECTION 8 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

Section 8.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Customer Service at 1-877-269-5706 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048).

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

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

2. **You'll be asked to sign the written notice to show that you got it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice ***doesn't* mean** you're agreeing on a discharge date.
3. **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
   - To look at a copy of this notice in advance, call Customer Service at 1-877-269-5706 (TTY users call 711) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get the notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 8.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Customer Service at 1-877-269-5706 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP), for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*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 can 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 don't meet this deadline, contact us.** If you decide to stay in the hospital after your planned discharge date, *you may have to pay all the costs* for hospital care you get after your planned discharge date.

Once you ask for an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it 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 at 1-877-269-5706 (TTY users call 711) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048.) Or you can get a sample notice online at www.CMS.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them.
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice 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 independent review organization says yes, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You'll have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says no, they're saying that your planned discharge date is medically appropriate. If this happens, **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 independent review organization says no to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 8.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. **Section 10** talks more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health 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 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying for your care*.

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

Section 9.1 We'll tell you in advance when your coverage will be ending

Legal Term:

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

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

Section 9.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Customer Service at 1-877-269-5706 (TTY users call 711). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

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

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) 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 want to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization.

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

Legal Term:

Detailed Explanation of Non-Coverage. Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you, or your representative, why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want to.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers told us of your appeal, you'll 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 its decision.

What happens if the reviewers say yes?

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

What happens if the reviewers say no?

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

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

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

Section 9.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go 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 10 of this chapter tells more about the process for Level 3, 4, and 5 appeals.

SECTION 10 Taking your appeal to Levels 3, 4 and 5

Section 10.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.

- If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
- If we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute.

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

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

Level 5 appeal

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

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

Section 10.2 Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process.

Section 10.3 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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 answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.
- **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 don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

Level 4 appeal

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

- **If the answer is yes, the appeals process is over.** We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision.

- **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 the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

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

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

Making complaints

SECTION 11 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 11.1 What kinds of problems are handled by the complaint process

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and 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 got (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're being encouraged to leave our plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Customer Service or other staff at our plan? ○ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are about the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs 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 11.2 How to make a complaint

Legal Terms:

A **complaint** is also called a **grievance.**

Making a complaint is called **filing a grievance.**

Using the process for complaints is called **using the process for filing a grievance.**

A **fast complaint** is called an **expedited grievance.**

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

- **Calling Customer Service at 1-877-269-5706 (TTY users call 711) is usually the first step.** If there's anything else you need to do, Customer Service will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing.
    - You or someone you name may file a grievance. The person you name would be your "representative". You may name a relative, friend, lawyer, advocate, doctor or anyone else to act for you.
    - If you want someone to act for you who is not already authorized by the court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.
    - A grievance must be filed either verbally or in writing within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
    - A fast grievance can be filed concerning a plan decision not to conduct a fast response to a coverage decision or appeal, or if we take an extension on a coverage decision or appeal. We must respond to your expedited grievance within 24 hours.
- **Whether you call or write, you should call Customer Service at 1-877-269-5706 (TTY users call 711) right away.** You can make the complaint at any time after you had the problem you want to complain about.

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

- **If possible, we'll answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call.
- **Most complaints are answered within 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing.

- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 11.3 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 2 extra options:

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

Or

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

Section 11.4 You can also tell Medicare and Medicaid about your complaint

You can submit a complaint about Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

You can also contact the state's Medicaid with a complaint by calling the New York State Medicaid at 1-800-541-2831 (TTY: 711).

You also have a right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- **Phone:** 1-866-712-7197
- **Mail:** New York State Department of Health Bureau of Managed Long Term Care Technical Assistance Center 99 Washington Ave/ One Commerce Plaza 16th Fl Albany, NY 12210
- **E-mail:** mltctac@health.ny.gov

You also have the right to contact the New York State Department of Health about your complaint. Contact the Department of Health by:

- **Phone:** 1-800-206-8125

- **Mail:** New York State Department of Health Managed Care Complaint Unit OHIP DHPCO 1CP-1609 Albany, New York 12237
- **E-mail:** managedcarecomplaint@health.ny.gov

CHAPTER 10:

Ending membership in our plan

SECTION 1 Ending your membership in our plan

Ending your membership in Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) may be **voluntary** (your own choice) or **involuntary** (not your own choice):

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

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs and you'll 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 may be able to end your membership because you have Medicare and Medicaid

Most people with Medicare can end their membership only during certain times of the year. Because you have Medicaid, you can end your membership in our plan by choosing one of the following Medicare options in any month of the year:

- Original Medicare *with* a separate Medicare prescription drug plan,
- Original Medicare *without* a separate Medicare prescription drug plan (If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.), or
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for a continuous period of 63 days or more, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- Call your State Medicaid Office at 1-800-541-2831 to learn about your Medicaid plan options.

- Other Medicare health plan options are available during the **Open Enrollment Period**. Section 2.2 tells you more about the Open Enrollment Period.
- **Your membership will usually end on the first day of the month after we get your request to change your plans**. Your enrollment in your new plan will also begin on this day.

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

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

- The **Open 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 drug coverage.
  - Original Medicare *with* a separate Medicare drug plan.
  - Original Medicare *without* a separate Medicare drug plan.
  - If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

You get Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and don't enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you've opted out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage begins on January 1.

Section 2.3 You can end your membership during the Medicare Advantage Open Enrollment Period

You can make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period** each year.

- **The 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 Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.

- Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.

- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan, or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will start the first day of the month after the drug plan gets your enrollment request.

Section 2.4 In certain situations, you can end your membership during a Special Enrollment Period

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

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

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for your Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE)
- **Note:** If you're in a drug management program, you may only be eligible for certain Special Enrollment Periods. Chapter 5, Section 10 tells you more about drug management programs.
- **Note:** Section 2.1 tells you more about the special enrollment period for people with Medicaid.

Enrollment time periods vary depending on your situation.

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

- Another Medicare health plan with or without drug coverage,
- Original Medicare *with* a separate Medicare drug plan,
- Original Medicare *without* a separate Medicare drug plan.
- If eligible, an integrated D-SNP that provides your Medicare and most or all of your Medicaid benefits and services in one plan.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

If you get Extra Help from Medicare to pay for your drug coverage drugs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Your membership will usually end on the first day of the month after your request to change our plan.

Note: Section 2.1 and Section 2.2 tell you more about the special enrollment period for people with Medicaid and Extra Help.

Section 2.5 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Customer Service at 1-877-269-5706 (TTY users call 711)**
- Find the information in the ***Medicare & You 2026*** handbook
- Call **Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan	• Enroll in the new Medicare health plan. • You'll automatically be disenrolled from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) when your new plan's coverage starts.
Original Medicare *with* a separate Medicare drug plan	• Enroll in the new Medicare drug plan. • You'll automatically be disenrolled from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) when your new drug plan's coverage starts.

To switch from our plan to:	Here's what to do:
Original Medicare *without* a separate Medicare drug plan	• **Send us a written request to disenroll**. Call Customer Service at 1-877-269-5706 (TTY users call 1-877-486-2048) if you need more information on how to do this. • You can also call **Medicare**, at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) when your coverage in Original Medicare starts.

Note: If you disenroll from Medicare drug coverage, no longer receive Extra Help, and go without creditable drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

For questions about your New York State Medicaid benefits, contact the New York State Medicaid at 1-800-541-2831, TTY 711, Monday through Friday 8:00AM-8:00PM, Saturday 9:00AM-1:00PM Ask how joining another plan or returning to Original Medicare affects how you get your New York State Medicaid coverage.

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

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

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

SECTION 5 Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) must end our plan membership in certain situations

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B
- If you're no longer eligible for Medicaid. As stated in Chapter 1, Section 2.1, our plan is for people who are eligible for both Medicare and Medicaid. To remain enrolled in the plan, Medicare requires that you continue to be eligible for both Medicare and Medicaid. If the plan is notified of your loss of Medicaid eligibility, we will notify you in writing. The plan will continue to provide care for 6 full calendar months for members who lose Medicaid eligibility, as long as the plan can provide appropriate care and the individual can reasonably be expected to again meet eligibility requirements within 6 months. If the member does not re-qualify within the plan's period of deemed continued eligibility (6 months), the member will be involuntarily disenrolled from the plan, with proper notice, at the end of this period. The period of deemed continued eligibility begins the first of the month following the month in which information regarding the loss is available to the organization and communicated to the enrollee, including cases of retroactive Medicaid terminations.
- If you move out of our service area
- If you’re away from our service area for more than 6 months
    - If you move or take a long trip, call Customer Service at 1-877-269-5706 (TTY users call 711) to find out if the place you’re moving or traveling to is in our plan's area
- If you become incarcerated (go to prison)
- If you’re no longer a United States citizen or lawfully present in the United States
- If you lie or withhold information about other insurance, you have that provides drug coverage
- If you intentionally give us incorrect information when you’re enrolling in our plan, and that information affects your eligibility for our plan (We can’t make you leave our plan for this reason unless we get permission from Medicare first)
- If you continuously behave in a way that’s disruptive and makes it difficult for us to provide medical care for you and other members of our plan (We can’t make you leave our plan for this reason unless we get permission from Medicare first)
- If you let someone else use your membership card to get medical care (We can’t make you leave our plan for this reason unless we get permission from Medicare first)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General

- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan.

If you have questions or want more information on when we can end your membership, call Customer Service at 1-877-269-5706 (TTY users call 711).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 11:

Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, age, 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, 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 www.HHS.gov/ocr/index.html.

If you have a disability and need help with access to care, call Customer Service at 1-877-269-5706 (TTY users call 711). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP), 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

You have 36 months from the date the prescription was filled to file a paper claim. This applies to claims you submit, and not to pharmacy or provider filed claims.

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

You may submit such claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 1407 Church Street Station
New York, NY 10008-1407

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 1-877-269-5706, 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 facilities; and
- Temporarily reduce cost sharing for plan-approved out-of-network services to the in-network cost-sharing amounts.

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 12:

Definitions

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

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

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

Biological Product – A prescription drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand Name Drug – A prescription drug that's manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

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

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

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 about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy 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 drug. 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 or drugs are gotten. Cost sharing includes any combination of the following 3 types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of 6 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the drugs covered by our plan.

Covered Services – The term we use to mean all 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's 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 don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It

may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

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

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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

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

Durable Medical Equipment (DME) – Certain medical equipment that's 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're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's 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.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive

the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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

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

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

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

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 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.

Integrated D-SNP – A D-SNP that covers Medicare and most or all Medicaid services under a single health plan for certain groups of individuals eligible for both Medicare and Medicaid. These individuals are also known as full-benefit dually eligible individuals.

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

Integrated 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.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) – Go to Extra Help.

Managed Long Term Services and Supports (MLTSS) – A program that provides home and community based services for members that require the level of care typically provided in a nursing facility, and allows them to receive necessary care in a residential or community setting. MLTSS services include (but are not limited to): assisted living services; cognitive; speech; occupational and physical therapy; chore services; home-delivered meals; residential modifications (such as the installation of ramps or grab bars); vehicle modifications; social adult day care; and nonmedical transportation. MLTSS is available to members who meet certain clinical and financial requirements.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for covered Part A and Part B services. Amounts you pay for your Medicare Part A and Part B premiums and prescription drugs don't count toward the maximum out-of-pocket amount. If you're eligible for Medicare cost-sharing assistance under Medicaid, you aren't responsible for paying any out-of-pocket costs toward the maximum out-of-pocket amount for covered Part A and Part B services. (**Note:** Because our members also get help from Medicaid, very few members ever reach this out-of-pocket maximum.)

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 Accepted Indication – A use of a drug that's either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

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 its plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**.

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

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

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.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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 isn't 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 – The doctors and other health care professionals, medical groups, hospitals, and other health care facilities or providers that have an agreement with us to provide covered services to our members and to accept our payment and any plan cost-sharing as payment in full. (See Chapter 3, Section 2)

Network Pharmacy –A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they're filled at one of our network pharmacies.

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**.

Open 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.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

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

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

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

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

Part C – Go to Medicare Advantage (MA) plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded from Part D coverage by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan. If you lose Extra Help, you may be subject to the late enrollment penalty if you go 63 days or more in a row without Part D or other creditable drug coverage.

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

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

Primary Care Provider (PCP) –The doctor or other provider you see first for most health problems. 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 services or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but 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.

Quantity Limits – A management tool that's designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This

includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

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. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

LANGUAGE ASSISTANCE

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call 877-269-5706 (TTY 711).	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al 877-269-5706 TTY 711).	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 877-269-5706 (TTY 711)。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم 877-269-5706 (TTY 711).	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. 877-269-5706 (TTY 711) 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру 877-269-5706 (TTY 711).	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il 877-269-5706 (TTY 711).	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le 877-269-5706 (TTY 711).	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele 877-269-5706 (TTY 711).	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט 877-269-5706 (TTY 711) .	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: 877-269-5706 (TTY 711).	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa 877-269-5706 (TTY 711).	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। 877-269-5706 (TTY 711) -এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi 877-269-5706 (TTY 711).	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο 877-269-5706 (TTY 711).	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں 877-269-5706 (TTY 711) ۔	Urdu

Nondiscrimination Notice

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

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

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

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

- Qualified interpreters
- Information written in other languages

If you need these services, call Customer Service (TTY: **711**) for help.

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

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

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

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

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.

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.

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Anthem HealthPlus Full Dual Advantage LTSS (HMO D-SNP) Customer Service

Method	Customer Service – Contact Information
CALL	1-877-269-5706 (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 1-877-269-5706 (TTY users call 711) 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 1407 Church Street Station New York, NY 10008-1407
WEBSITE	www.anthem.com

New York Health Insurance Information, Counseling and Assistance Program (HIICAP)
New York Health Insurance Information, Counseling and Assistance Program (HIICAP) 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	1-800-701-0501 8:30 a.m. - 5 p.m. local time, Monday - Friday
TTY	711
Write	New York State Office for the Aging 2 Empire State Plaza 5th Floor Albany, NY 12223
Website	https://aging.ny.gov/health-insurance-information-counseling-and-assistance-program-hiicap