



Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member Handbook

January 1 - December 31, 2027

Your Health and Drug Coverage under Anthem I PathWays Dual Care Advantage (HMO D-SNP)

Member Handbook Introduction

This *Member Handbook*, otherwise known as the *Evidence of Coverage*, tells you about your coverage under our plan through December 31, 2027. It explains health care services, behavioral health (mental health and substance use disorder) services, drug coverage, and long-term services and supports. Key terms and their definitions appear in alphabetical order in **Chapter 12** of this *Member Handbook*.

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

When this *Member Handbook* says “we,” “us,” “our,” or “our plan,” it means Anthem I PathWays Dual Care Advantage (HMO D-SNP).

This document is available for free in Spanish and Chinese.

You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-833-412-4405 (TTY 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at www.anthem.com.

We have free interpreter services to answer any questions that you may have about our health or drug plan. To get an interpreter just call us at 1-833-412-4405. Someone that speaks Arabic, Armenian, Cambodian, Chinese, Farsi, French, French Creole, Hindi, Hmong, Italian, German, Japanese, Korean, Laotian, Mien, Polish, Portuguese, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, or Vietnamese can help you. This is a free service.

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member Services at 1-833-412-4405 (TTY: 711), 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

Español (Spanish) – ATENCIÓN: Si necesita ayuda en su idioma, tiene a su disposición servicios gratuitos de asistencia en otros idiomas. También puede obtener ayudas y servicios auxiliares adecuados gratuitos para proporcionar información en formatos accesibles. Llame al número de teléfono que figura en su tarjeta de identificación del miembro.

العربية (Arabic) – تنبيه: إذا كنت تحتاج إلى المساعدة بلغتك، فإن خدمات المساعدة اللغوية المجانية متاحة لك. كما تتوفر مساعدات وخدمات مساعدة مناسبة لتوفير المعلومات بأشكال يسهل الوصول إليها مجاناً. اتصل برقم الهاتف الموجود على بطاقة ID هوية العضو الخاصة بك.

简体中文 (Chinese Simplified) – 注意: 如果您在您的语言方面需要帮助, 我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助工具和服务, 以可访问的格式提供信息。请拨打您的会员 ID 卡上的电话号码。

繁體中文 (Chinese Traditional) – 注意: 如果您在您的語言方面需要協助, 我們可以為您提供免費的語言協助服務。我們還免費提供適當的輔助工具 and 服務, 以無障礙格式提供資訊。請撥打您的會員 ID 卡上的電話號碼。

Français (French) – ATTENTION : Si vous avez besoin d'aide dans votre langue, des services gratuits d'assistance linguistique sont disponibles. Des aides et services auxiliaires appropriés permettant de fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le numéro de téléphone figurant sur votre carte d'ID de membre.

Deutsch (German) – ACHTUNG: Wenn Sie Hilfe in Ihrer Sprache benötigen, stehen Ihnen kostenlose Dienste zur sprachlichen Unterstützung zur Verfügung. Außerdem sind kostenlose Hilfsmittel und Dienste verfügbar, um Informationen in zugänglichen Formaten bereitzustellen. Rufen Sie die Telefonnummer auf Ihrer Mitglieds-ID-Karte an.

Kreyòl Ayisyen (Haitian Creole) – ATANSYON: Si w bezwen èd nan lang ou, sèvis asistans lengwistik gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm ki aksesib disponib tou san w p ap peye. Rele nimewo telefòn ki sou kat ID manm ou an.

हिंदी (Hindi) – ध्यान दें: यदि आपको अपनी भाषा में सहायता चाहिए, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। पहुँच योग्य प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। अपने सदस्य ID कार्ड पर दिए गए फ़ोन नंबर पर कॉल करें।

Igbo (Igbo) – NLEBA AMA: Ọ bụrụ na ịchọrọ enyemaka n'asụsụ gị, enyemaka asụsụ dị maka gị. E nwekwara ike inye aka na ọrụ enyemaka kwesịrị ekwesị iji nye ozi n'ụdị dị mfe ịnweta n'efu. Kpọọ nọmba ekwentị dị na kaadị njirimara onye otu gị.

日本語 (Japanese) – 注意: ご使用の言語でのサポートが必要な場合には、無料の言語支援サービスをご提供しています。適切な補助器具・サービスも、利用者がアクセスしやすい方法でご提供しています。こちらでも無料でご利用いただけます。必要な情報取得にお役立てください。会員 ID カードに記載されている電話番号にお電話ください。

ភាសាខ្មែរ (Khmer) – សូមយកចិត្តទុកដាក់៖ ប្រសិនបើអ្នកត្រូវការជំនួយជាភាសារបស់អ្នក សេវាជំនួយភាសាឥតគិតថ្លៃ មានផ្តល់ជូនអ្នក។ មានផ្តល់ជូនដោយឥតគិតថ្លៃនូវសេវាកម្ម និងឧបករណ៍ជំនួយសមស្របដើម្បីផ្តល់ព័ត៌មានក្នុងទម្រង់ បែបបទដែលអាចចូលប្រើបានផងដែរ។ សូមហៅទូរសព្ទទៅលេខនៅលើកាត ID សមាជិករបស់អ្នក។

한국어 (Korean) – 주의: 귀하의 언어로 도움이 필요하신 경우, 무료 언어 지원 서비스를 이용하실 수 있습니다. 대체 형식으로 정보를 제공하기 위한 적절한 보조 장치 및 서비스도 무료로 제공됩니다. 가입자 ID 카드에 기재된 전화 번호로 전화해 주십시오.

Deutsch (Pennsylvania Dutch) – WICH DICH: Wann du Hilf brauchsch in dei eegni Schprooch, kenne mir dich helfe fer Sache verschteh, unni as es dich ennich eppes koschde zellt. Mir hen en latt differnti Wege fer dich helfe aa wann du Druwwel hoscht fer sehne odder heere, aa fer ken Koscht. Call der Number uf dei ID Card.

ਪੰਜਾਬੀ (Punjabi) – ਧਿਆਨ ਦਿਓ: ਜੇਕਰ ਤੁਹਾਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਦੀ ਲੋੜ ਹੈ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਭਾਸ਼ਾਈ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਪਹੁੰਚਯੋਗ ਫਾਰਮੈਟਾਂ ਵਿੱਚ ਜਾਣਕਾਰੀ ਪ੍ਰਦਾਨ ਕਰਨ ਲਈ ਢੁਕਵੇਂ ਸਹਾਇਕ ਸਾਧਨ ਅਤੇ ਸੇਵਾਵਾਂ ਵੀ ਮੁਫਤ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ਮੈਂਬਰ ID ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਫੋਨ ਨੰਬਰ 'ਤੇ ਕਾਲ ਕਰੋ।

Kiswahili (Swahili) – ANGALIZO: Ikiwa unahitaji msaada kwa lugha yako, huduma za usaidizi wa lugha zinapatikana kwako bila malipo. Vifaa na huduma saidizi vinavyofaa kwa ajili ya kutoa taarifa katika miundo inayopatikana kwa urahisi zinapatikana pia bila malipo. Piga nambari ya simu iliyo kwenye ID yako ya uanachama.

Tagalog (Tagalog) – PAUNAWA: Kung kailangan mo ng tulong sa iyong wika, mayroong available na mga libreng serbisyo sa tulong sa wika para sa iyo. Ang naaangkop na mga karagdagang tulong at serbisyo para magbigay ng impormasyon sa mga naa-access na format ay available rin nang walang bayad. Tawagan ang numero ng telepono sa iyong ID card ng miyembro.

Twí (Twi) – HYƐ NO NSO: Sɛ wohia mmɔa wɔ wɔ kasa mu a, kasa mu mmɔa a wontua hwee wɔ ho ma wo. Nneema ne mmɔa a eho hia nso wɔ ho a wɔde ma kwa senea ɛbeyɛ a wobɛtumi anya nsem no wɔ okwan a ɛye mmere sɛ wobete ase. Frɛ fon noma no a ɛwɔ ID kaade no so no.

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

דיש (Yiddish) – אויפמערקזאמקייט: אויב איר דאַרפֿט הילף אין אייער שפּראַך, פּרײַ שפּראַך הילף באַדינונגס זענען בנימצא צו איר. צונעמען אַגזיליערי אידס און באַדינונגס צו צושטעלן אינפֿארמאַציע אין צוטריטלעך פֿאַרמאַטירונגען זענען אויך פּרײַ. רופן די טעלעפֿאָן נומער אויף דיין מיטגליד ID קאַרט.

Yorùbá (Yoruba) – ÀKÍYÈSÍ: Tí o bá nílò ìrànlowọ ní èdè rẹ, àwọn isẹ ìrànlowọ èdè ọfẹ wà fún ọ. Àwọn ohun èlò ìrànlowọ àti isẹ ìrànlowọ tó yẹ láti pèsè ìwífún ní àwọn ọ̀nà tí a lè gbà tún ráàyèsì wà lófẹ́. Pe nọmbà fòònù tó wà lórí kààdì ìdánimọ ọmọ ẹgbẹ rẹ.

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Disclaimers

- Anthem Blue Cross and Blue Shield is an HMO D-SNP plan with a Medicare contract and a contract with the Indiana Medicaid program. Enrollment in Anthem Blue Cross and Blue Shield depends on contract renewal. Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensee of the Blue Cross Blue Shield Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc.
- This is not a complete list. The benefit information is a brief summary, not a complete description of benefits. For more information contact the plan or read the Anthem I PathWays Dual Care Advantage (HMO D-SNP) *Member Handbook*.
- Using opioid medications to treat pain for more than seven days has serious risks like - addiction, overdose, or even death. If your pain continues, talk to your doctor about alternative treatments with less risk. Some choices to ask your doctor about are: Non opioid medications, acupuncture, or physical therapy to see if they are right for you. Find out how your plan covers these options by calling Member Services at 1-833-412-4405 (TTY: 711).
- CarelonRx, Inc. is an independent company providing pharmacy benefit management services on behalf of your health plan.
- Benefits and/or copayments may change on January 1, 2028.
- Our covered drugs, pharmacy network, and/or provider network may change at any time. You'll get a notice about any changes that may affect you at least 30 days in advance.



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Chapter 1: Getting started as a member

Introduction

This chapter includes information about Anthem I PathWays Dual Care Advantage (HMO D-SNP), a health plan that covers all of your Medicare and Indiana PathWays for Aging services, and your membership in it. It also tells you what to expect and what other information you will get from us. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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A. Welcome to our plan

Our plan provides Medicare and Indiana PathWays for Aging services to individuals who are eligible for both programs. Our plan includes primary medical providers (PMPs), hospitals, pharmacies, providers of long-term services and supports, behavioral health providers, and other providers. We also have care coordinators, service coordinators, and care teams to help you manage your providers and services. They all work together to provide the care you need.

Indiana PathWays for Aging is a managed care program for Indiana Medicaid members that are:

- 60 years of age or older,
- are eligible for full-coverage for aged, blind or disabled category (with or without Medicare),
- can be receiving long-term support services including:
 - residing in a nursing or long-term care facility,
 - approved for Home and Community-Based (waiver) Services, or
 - on the Behavioral and Primary Health Coordination program, **and**
- meet Indiana Medicaid standard program income and asset limits.

B. Information about Medicare and Indiana PathWays for Aging

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Indiana PathWays for Aging

Indiana PathWays for Aging is the name of Indiana's Medicaid program. Indiana PathWays for Aging is run by the state and is paid for by the state and the federal government. Indiana PathWays for Aging helps people with limited incomes and resources pay for Long-Term Services and Supports (LTSS) and medical costs. It covers extra services and drugs not covered by Medicare.

Each state decides:

- what counts as income and resources,



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- who is eligible,
- what services are covered, **and**
- the cost for services.

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

Medicare and the state of Indiana approved our plan. You can get Medicare and Indiana PathWays for Aging services through our plan as long as:

- we choose to offer the plan, **and**
- Medicare and the state of Indiana allow us to continue to offer this plan.

Even if our plan stops operating in the future, your eligibility for Medicare and Indiana PathWays for Aging services isn't affected.

C. Advantages of our plan

You will now get all your covered Medicare and Indiana PathWays for Aging services from our plan, including drugs. **You don't pay extra to join this health plan.**

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

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



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D. Our plan's service area

Our service area includes these counties in Indiana: Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, Dearborn, Decatur, DeKalb, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, Lagrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley, Rush, Scott, Shelby, Spencer, St. Joseph, Starke, Steuben, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wayne, Wells, White, and Whitley.

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

You can't stay in our plan if you move outside of our service area. Refer to **Chapter 8** of your *Member Handbook* for more information about the effects of moving out of our service area.

E. What makes you eligible to be a plan member

You're eligible for our plan as long as you:

- live in our service area (incarcerated individuals are not considered living in the service area even if they are physically located in it), **and**
- have both Medicare Part A and Medicare Part B, **and**
- are a United States citizen or national, or an eligible non-citizen national, or an eligible non-citizen, and
- are currently eligible for Indiana PathWays for Aging

Indiana PathWays for Aging is a managed care program for Indiana Medicaid members that are:

- 60 years of age or older
- are eligible for full-coverage for aged, blind or disabled category (with or without Medicare),
- meet Indiana Medicaid standard program income and asset limits.
- If you lose your Indiana PathWays for Aging eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem I PathWays Dual Care Advantage (HMO D-SNP). When your Indiana PathWays for Aging coverage ends, we won't pay for your Indiana PathWays for Aging benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medicaid used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.



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In addition, if you lose your Indiana Medicaid eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

For additional information about how a change in your Indiana Medicaid eligibility may affect your benefits and cost sharing, please contact Member Services.

We'll assist you to regain your Indiana PathWays for Aging eligibility. If your Indiana PathWays for Aging eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Indiana PathWays for Aging benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and cost-sharing assistance for which you again qualify. If you can't regain Indiana PathWays for Aging within six months we'll disenroll you from Anthem I PathWays Dual Care Advantage (HMO D-SNP). If you regain Indiana PathWays for Aging eligibility after we disenroll you from our Medicare coverage you'll need to contact us to reenroll in the plan.

- For Native American or Alaskan Native members, you have the right to get services from a Native American and/or Alaskan Native health care provider. If you don't want to be enrolled in the PathWays program, contact the program helpline for Indiana PathWays for Aging at 1-877-284-9294.

Call Member Services for more information.

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

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

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

We reach out to you to complete the HRA. We can complete the HRA by an in-person visit, telephone call, or mail. We'll reach out to you annually to see if any of your needs have changed.

We'll send you more information about this HRA.

If our plan is new for you, you can keep using the doctors you use now for a certain amount of time, if they are not in our network. We call this continuity of care. If they are not in our network, you can keep your current providers and service authorizations at the time you enroll for up to 12 months if all of the following conditions are met:

- You, your representative, or your provider asks us to let you keep using your current provider.
- We establish that you had an existing relationship with a primary or specialty care provider, with some exceptions. When we say "existing relationship," it means that you saw an out-of-network



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

provider at least once for a non-emergency visit during the 12 months before the date of your initial enrollment in our plan.

- o We determine an existing relationship by reviewing your available health information or information you give us.
- o We have 30 days to respond to your request. You can ask us to make a faster decision, and we must respond in 15 days. You can make this request by calling 1-833-412-4405. If you are at risk of harm, we must respond within 3 days.
- o You or your provider must show documentation of an existing relationship and agree to certain terms when you make the request.

Note: You can make this request for providers of Durable Medical Equipment (DME) for at least 90 days until we authorize a new rental and have a network provider deliver the rental. Although you cannot make this request for providers of transportation or other ancillary providers, you can make a request for services of transportation or other ancillary services not included in our plan.

After the continuity of care period ends, you will need to use doctors and other providers in the Anthem I PathWays Dual Care Advantage (HMO D-SNP) network, unless we make an agreement with your out-of-network doctor. A network provider is a provider who works with the health plan. Refer to **Chapter 3** of your *Member Handbook* for more information on getting care.

G. Your care team and care plan

G1. Care team

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

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

G2. Care plan

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

Your care plan includes:

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

H. Summary of Important Costs

Our plan has no premium.

Your costs may include the following:

- Monthly Medicare Part B Premium (**Section H1**)

H1. 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 E** 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 I PathWays Dual Care Advantage (HMO D-SNP) members, Medicaid pays for your Medicare 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 Medicare Part B. You may also pay a premium for Medicare Part A if you aren't eligible for premium-free Medicare Part A. **In addition, please contact Member Services or your care coordinator and inform them of this change.**

I. This Member Handbook

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

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

The contract is in effect for the months you're enrolled in our plan between January 1 and December 31, 2027.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

J. Other important information you get from us

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

J1. Your Member ID Card

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

Anthem  PathWays DUAL CARE		MedicareRx Prescription Drug Coverage
[Plan Name] is an Indiana PathWays for Aging plan that contracts with both Medicare and Indiana PathWays for Aging		
Member Name: Lnammond Hnamments		
PathWays ID: 123X456YZ540 Member ID: EMQ103X32026		
Dual eligible members pay \$0 for plan covered medical services		
RxBIN: 020115 RxPCN: IS RxGRP: VM2A RxID: 103X32026		
CMS H0629-XXX-XXXX		

Member: Present this ID card before you receive Medicare or Medicaid services or supplies. See your Evidence of Coverage for covered services. For emergencies, dial 911 or go to the nearest Emergency Room (ER). If you are unsure if you need the ER, call the 24/7 Nurseline number on the card. For telehealth needs, go to livehealthonline.com .	
Provider: Do not bill FFS Medicare. Please submit claims to your local Blue Cross and Blue Shield plan. Include the 3-digit prefix that precedes the identification number listed on the front of the card. Or submit through the Anthem Avariety claims portal. Outside the plan's service area, benefits may be limited to Emergency care.	
Member Service: 1-833-412-4405 Member Svc Text Line: 1-888-998-1034 TTY/TDD Line: 711 Member Pharmacy Svc: 1-833-337-1283 Help for Pharmacists: 1-833-377-4266	Provider Service: 1-833-569-4739 Dental Member Service: 1-888-700-0992 24/7 Nurseline: 1-855-658-9249 Care Coordination: 1-833-412-4405 BH Crisis Line: 1-833-412-4405
Anthem Blue Cross and Blue Shield is the trade name of Anthem Insurance Companies, Inc. Independent licensees of the Blue Cross Blue Shield Association. anthem.com Possession of this card does not guarantee eligibility for benefits. Send paper claims to: Medical: P.O. Box 105187 Atlanta, GA 30348 Pharmacy: Claims Department- Part D Services P.O. Box 52077, Phoenix, AZ 85072-2077 Issue Date: 09/22/2026	

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

As long as you're a member of our plan, you don't need to use your red, white, and blue Medicare card or your Indiana PathWays for Aging card to get most services. Keep those cards in a safe place, in case you need them later. If you show your Medicare card instead of your Member ID Card, the provider may bill Medicare instead of our plan, and you may get a bill. You may be asked to show your Medicare card if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials). Refer to **Chapter 7** of this *Member Handbook* to find out what to do if you get a bill from a provider.

J2. Provider and Pharmacy Directory

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

You can also refer to the *Provider and Pharmacy Directory* at the web address at the bottom of the page.

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

Definition of network providers

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

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

Definition of network pharmacies

- Network pharmacies are pharmacies that agree to fill prescriptions for our plan members. Use the *Provider and Pharmacy Directory* to find the network pharmacy you want to use.
- Except during an emergency, you must fill your prescriptions at one of our network pharmacies if you want our plan to pay for them.

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

List of Durable Medical Equipment (DME)

This list tells you the brands and makers of DME that we cover. The most recent list of brands, makers, and suppliers is also available on our website at the address at the bottom of the page. Refer to **Chapter 3 and Chapter 4** of this *Member Handbook* to learn more about DME equipment.

J3. List of Covered Drugs

Our plan has a List of Covered Drugs. We call it the Drug List for short. It tells you which drugs our plan covers. 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 the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

replaced as described in **Chapter 5, Section C**. Medicare approved the Anthem I PathWays Dual Care Advantage (HMO D-SNP) *Drug List*.

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

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

J4. The Explanation of Benefits

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

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

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

K. Keeping your membership record up to date

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

We need this information to make sure that we have your correct information in our records. 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.

Tell us right away about the following:

- changes to your name, address, or phone number;
- changes to any other health insurance coverage, such as from your employer, your spouse's employer, or your domestic partner's employer, or workers' compensation;
- any liability claims, such as claims from an automobile accident;
- admission to a nursing facility or hospital;
- care from a hospital or emergency room;
- changes in your caregiver (or anyone responsible for you); **and**



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- you participate in a clinical research study. (**Note:** You're not required to tell us about a clinical research study you intend to participate in, but we encourage you to do so.)

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

The Division of Family Resources (DFR) has local offices in every county around the state to assist individuals in changes listed above. Please be sure to also call DFR at 1-800-403-0864 for any of the above changes.

K1. Privacy of personal health information (PHI)

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 2: Important phone numbers and resources

Introduction

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

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. Member Services

CALL	1-833-412-4405. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. We have free interpreter services for people who don't speak English.
TTY	711. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
FAX	1-877-664-1504
WRITE	P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
 - A coverage decision about your health care is a decision about:
 - your benefits and covered services **or**
 - the amount we pay for your health services.
 - Call us if you have questions about a coverage decision about your health care.
 - To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your health care
 - An appeal is a formal way of asking us to review a decision we made about your coverage and asking us to change it if you think we made a mistake or disagree with the decision.
 - To learn more about making an appeal, refer to **Chapter 9** of this *Member Handbook* or contact Member Services.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- complaints about your health care
 - o You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
 - o You can call us and explain your complaint at 1-833-412-4405.
 - o If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above).
 - o You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
 - o To learn more about making a complaint about your health care, refer to **Chapter 9** of this Member Handbook.
- coverage decisions about your drugs
 - o A coverage decision about your drugs is a decision about:
 - your benefits and covered drugs **or**
 - the amount we pay for your drugs.
 - o This applies to your Medicare Part D drugs and Indiana PathWays for Aging and over-the-counter drugs.
 - o For more on coverage decisions about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your drugs
 - o An appeal is a way to ask us to change a coverage decision.
 - o For more on making an appeal about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- complaints about your drugs
 - o You can make a complaint about us or any pharmacy. This includes a complaint about your drugs.
 - o If your complaint is about a coverage decision about your drugs, you can make an appeal. (Refer to the section above.)



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o You can send a complaint about our plan to Medicare. You can use an online form at www.medicare.gov/my/medicare-complaint. Or you can call 1-800-MEDICARE (1-800-633-4227) to ask for help.
- o For more on making a complaint about your drugs, refer to **Chapter 9** of this *Member Handbook*.
- payment for health care or drugs you already paid for
 - o For more on how to ask us to pay you back, or to pay a bill you got, refer to **Chapter 7** of this *Member Handbook*.
 - o If you ask us to pay a bill and we deny any part of your request, you can appeal our decision. Refer to **Chapter 9** of this *Member Handbook*.

B. Your Care Coordinator

A Anthem I PathWays Dual Care Advantage (HMO D-SNP) care coordinator is one main person for you to contact. This person helps to manage all your providers and services and makes sure you get what you need. Call Member Services at 1-833-412-4405 (TTY: 711) if you need help reaching your care coordinator.

CALL	1-833-412-4405. This call is free. Monday through Friday from 8 a.m. to 8 p.m. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. Monday through Friday from 8 a.m. to 8 p.m.
FAX	1-877-664-1504
WRITE	P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com

Contact your care coordinator to get help with:

- questions about your health care
- questions about getting behavioral health (mental health and substance use disorder) services
- questions about transportation



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- questions about Long-term Services and Supports, involve help for people who need assistance with everyday tasks such as bathing, toileting, getting dressed, preparing food, and taking medications
- questions about supports and caregivers involved with you, such as family or friends who provide help
- questions about services provided at your home or in your community that could be provided in a nursing home or hospital
- questions about the Area Agency on Aging or another agency that may administer these services, your care coordinator will work with that agency

C. Indiana 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 Indiana, the SHIP is called Indiana SHIP.

Indiana SHIP is an independent state program (not connected with any insurance company or health plan) that gets money from the federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-452-4800 8 a.m. to 8 p.m., Monday through Friday
TTY	711
WRITE	311 W. Washington Street Indianapolis, IN 46204
WEBSITE	www.in.gov/ship/

Contact Indiana SHIP for help with:

- questions about Medicare
- Indiana SHIP counselors can answer your questions about changing to a new plan and help you:
 - o understand your rights,
 - o understand your plan choices,
 - o answer questions about switching plans,
 - o make complaints about your health care or treatment, **and**



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Commence Health Beneficiary and Family Centered (BFCC) QIO. This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. Commence Health BFCC-QIO is an independent organization. It's not connected with our plan.

CALL	1-888-524-9900
TTY	1-888-985-8775
WRITE	10820 Guilford Road, Suite 202 Annapolis Junction, MD 20701-1105
WEBSITE	www.commencehealthqio.cms.gov/en/states/indiana

Contact Commence Health BFCC-QIO for help with:

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

E. Medicare

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

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

CALL	1-800-MEDICARE (1-800-633-4227) Calls to this number are free, 24 hours a day, 7 days a week.
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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

TTY	1-877-486-2048. This call is free. This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
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. 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.

F. Indiana PathWays for Aging

Indiana PathWays for Aging helps with medical and long-term services and supports costs for people with limited incomes and resources.

You’re enrolled in Medicare and in Medicaid. If you have questions about the help you get from Medicaid, call Division of Family Resources (DFR) at 1-800-403-0864.

CALL	Division of Family Resources (DFR) at 1-800-403-0864. 8 a.m. to 4:30 p.m. local time, Monday through Friday
TTY	711



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

WRITE	P.O. Box 1810 Marion, IN 46952
WEBSITE	www.in.gov/fssa/dfr/

G. Indiana Long-Term Care Ombudsman

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

Indiana Long-Term Care Ombudsman isn't connected with our plan or any insurance company or health plan.

CALL	1-800-622-4484 or 1-317-232-7134 8 a.m. to 4:30 p.m. local time, Monday - Friday
TTY	711
WRITE	402 W. Washington Street, Suite W451 Indianapolis, IN 46207-7083 or P.O. Box 7083, MS 27 Indianapolis, IN 46207-7083
EMAIL	LongTermCareOmbudsman@ombudsman.IN.gov
WEBSITE	www.in.gov/ombudsman/long-term-care-ombudsman/contact-information/

H. Programs to Help People Pay for Drugs

The Medicare website (www.medicare.gov/basics/costs/help/drug-costs) provides information on how to lower your drug costs. For people with limited incomes, there are also other programs to assist, as described below.

H1. Extra Help from Medicare

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

H2. State Pharmaceutical Assistance Program (SPAP)

State Pharmaceutical Assistance Program (SPAP) is Hoosier Rx. To see if you qualify for Hoosier Rx:

- Call 1-866-267-4679. TTY users call 711.
- Visit www.in.gov/medicaid/members/member-programs/hoosierRx/ to apply online
- SPAP Mailing Address: Hoosier Rx, 402 W. Washington St Suite 372 Indianapolis, IN 46204

H3. AIDS Drug Assistance Program (ADAP)

ADAP helps ADAP-eligible people living with HIV/AIDS have access to life-saving HIV drugs. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the Indiana HIV Services Program (HSP).

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of the 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 receive assistance for information on eligibility criteria, covered drugs, or how to enroll in the program, please call Indiana HIV Services Program at 1-866-588-4948, 8 a.m. to 5 p.m., Monday through Friday.

I. Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment.

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

CALL	1-800-772-1213
	Calls to this number are free. Available 8 am to 7 pm, Monday through Friday. You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number is for people who have difficulty with hearing or speaking. You must have special telephone equipment to call it.
WEBSITE	www.ssa.gov/

J. Railroad Retirement Board (RRB)

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

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



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Chapter 3: Using our plan’s coverage for your health care and other covered services

Introduction

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

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A. Information about services and providers

Services are health care, long-term services and supports (LTSS), supplies, behavioral health services, prescription and over-the-counter drugs, equipment and other services. **Covered services** are any of these services that our plan pays for. Covered health care, behavioral health, and LTSS are in **Chapter 4** of your *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of your *Member Handbook*.

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

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

B. Rules for getting services our plan covers

Our plan covers all services covered by Medicare and Indiana PathWays for Aging. This includes behavioral health and LTSS.

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

- The care you get must be included in our Medical Benefits Chart in **Chapter 4** of this *Member Handbook*.
- The care must be **medically necessary**. By medically necessary, we mean you need services to prevent, diagnose, or treat your condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.
- For medical services, you must have a network **primary medical provider (PMP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PMP (go to **Section D1** for more information).
 - You don't need referrals from your PMP for emergency care or urgently needed care or to use a woman's health provider. You can get other kinds of care without having a referral from your PMP (go to **Section D1** for more information).
- **You must get your care from network providers** (for more information, go to **Section D**. in this chapter). Usually, we won't cover care from a provider who doesn't work with our health plan. This means that you'll have to pay the provider in full for the services you get. Here are some cases when this rule doesn't apply:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o We cover emergency or urgently needed care from an out-of-network provider (go to **Section I**).
- o If you need care that our plan covers and our network providers can't give it to you, you can get care from an out-of-network provider. You **MUST** get prior approval for these services. In this situation, we cover the care at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4**.
- o We cover kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible. If possible, call Member Services at the number at the bottom of the page before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

C. Your care coordinator

We're responsible for managing all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs, and the services that you receive to address these needs. This is called care coordination. We'll assign you a care coordinator when you enroll in our plan.

For those members that are eligible for LTSS please see section E for additional information on Service Coordination.

C1. What's a care coordinator

Your care coordinator will play a very important role. Your care coordinator is your primary contact person and is the first person that you should go to if you have any questions about your services. Your care coordinator will:

- Provide information about your coverage and answer your questions.
- Help you get the right kind of long-term services and supports in the right setting for you to address your needs.
- Coordinate all of your physical health, behavioral health (mental health or substance use disorder) and long-term services and supports needs.
- Help to fix problems and answer questions that you have about your care.
- Check at least once a year to make sure that you continue to need the level of care provided in a nursing home or, for Group 3, continue to be "at risk" of going into a nursing home.
- Communicate with your providers to make sure they know what's happening with your health care and to coordinate your service delivery.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

C2. How you can contact your care coordinator

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

C3. How you can change your care coordinator

If you would prefer to be seen by a different care coordinator, call Member Services to share your concerns and ask for another care coordinator.

D. Care from providers

D1. Care from a primary medical provider (PMP)

You must choose a primary care provider (PMP) to provide and manage your care.

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

Your PMP is your main health care provider. You'll see your PMP for your regular checkups. If you get sick, your PMP will be the first person you contact.

Your PMP can be:

- A family doctor
- OB/GYN
- Specialist who gives primary care
- A local health department or similar community clinic

Your choice of PMP

Your relationship with your PMP is important. So when you choose your PMP, try to think about the reasons below to help you. When you choose a PMP, you should:

- Choose a provider that you use now, **or**
- Choose a provider that someone you trust has suggested, **or**
- Choose a provider that is close to your home.

When you enroll with Anthem I PathWays Dual Care Advantage (HMO D-SNP), you will select a PMP by using our Provider and Pharmacy Directory. PMPs are listed by city and county, so you can find one close to where you live or work. The directory also shows you what languages are spoken in the PMP's office. If you need help choosing a PMP, call Member Services at 1-833-412-4405 (TTY: 711), 8 a.m. to 8 p.m., seven



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days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free.

When you select your PMP, you are also choosing the hospital(s) and specialty network(s) associated with your PMP.

The name and phone number of your PMP is printed on your membership card.

Option to change your PMP

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

To change your PMP, call Member Services at 1-833-412-4405, (TTY: 711) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. When you call, be sure to tell Member Services if you are using a specialist or getting other services that need your PMP's approval.

You can start using your PMP on the first day of the month after your request. For example, if you ask to change your PMP on September 13, you can start using your new primary care doctor on October 1.

We'll send you a new Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member ID Card with your new PMP's name and phone number.

D2. Care from specialists and other network providers

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

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

For certain services provided by specialists, either your PMP 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 Member Services. If you are



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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.

D3. When a provider leaves our plan

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

- Even if our network of providers change during the year, we must give you uninterrupted access to qualified providers.
- We'll notify you 30 days in advance that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary medical or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past three 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 three months.
- We help you select a new qualified in-network provider to continue managing your health care needs.
- If you're currently 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.
- If we can't find a qualified network specialist accessible to you, we must arrange an out-of-network specialist to provide your care when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out one of your providers is leaving our plan, contact us. We can help you choose a new provider to manage your care.
- If you think we haven't replaced your previous provider with a qualified provider or that we aren't managing your care well, you have the right to file a quality of care complaint to the Quality Improvement Organization (QIO), a quality of care grievance, or both. (Refer to **Chapter 9** for more information.)



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

D4. Out-of-network providers

If you use an out-of-network provider, the provider must be eligible to participate in Medicare and/or Indiana PathWays for Aging.

- We can't pay a provider who isn't eligible to participate in Medicare and/or Indiana PathWays for Aging.
- If you use a provider who isn't eligible to participate in Medicare, you must pay the full cost of the services you get.
- Providers must tell you if they aren't eligible to participate in Medicare.

E. Long-term services and supports (LTSS)

- Long-term Services and Supports are help for people who need assistance to do everyday tasks like bathing, toileting, getting dressed, making food, and taking medicine.
- Some of these supports also help caregivers involved with you, such as family or friends who provide help.
- Most of these types of services are provided at your home or in your community but could be provided in a nursing home or hospital.
- In some cases, an Area Agency on Aging or another agency may administer these services, and your care coordinator will work with that agency.

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

Behavioral health services are self-referral if rendered by an in-network provider. Members may self-refer, within the Contractor's network, for behavioral health services not provided by a psychiatrist, including mental health, substance abuse and chemical dependency services rendered by mental health specialty providers. The mental health providers to which the member may self-refer within network are:

- Outpatient mental health clinics
- Community mental health centers;
- Psychologists;
- Licensed psychologists;
- Health services providers in psychology (HSPPs);
- Licensed social workers;



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- Licensed clinical social workers;
- Psychiatric nurses;
- Independent practice school psychologists;
- Advanced practice nurses under IC 25-23-1-1 (b), credentialed in psychiatric or mental health nursing (applicable education and board certification); and persons holding a master's degree in social work, marital and family therapy or mental health counseling (under the Clinic Option).

G. How to get self-directed care

G1. What self-directed care is

Self-Direction means you or your representatives have the authority over certain services and take direct responsibility to manage their services with the assistance of a system of available supports.

Self-direction of services allows you to have the responsibility for managing aspects of service delivery in a person-centered planning process.

G2. Who can get self-directed care (for example, if it's limited to waiver populations)

Anyone meeting nursing facility level of care (NFLOC) and eligible for waiver services may elect to self-direct the following waiver services:

- Attendant Care
- Home and Community Assistance
- Skilled Respite

G3. How to get help in employing personal care providers

You are able to work with your assigned service coordinator. Service coordinator will submit a referral to Indiana's contracted Financial Management Services vendor, PALCO.

H. Transportation services

Please reference **Chapter 4** medical benefits chart for details on what transportation benefits are available to you.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

I1. Care in a medical emergency

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

- serious risk to your life and, if you're pregnant, loss of of an unborn child; **or**
- loss of or serious harm to bodily functions; **or**
- loss of a limb or function of a limb; **or**
- In the case of a pregnant woman in active labor, when:
 - o There isn't enough time to safely transfer you to another hospital before delivery.
 - o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child.

If you have a medical emergency:

- **Get help as fast as possible.** Call 911 or use the nearest emergency room or hospital. Call for an ambulance if you need it. You **don't** need approval or a referral from your PMP. You don't need to use a network provider. You can get covered emergency medical care whenever you need it, anywhere in the U.S. or its territories or worldwide, from any provider with an appropriate state license even if they're not part of your network.
- **As soon as possible, tell our plan about your emergency.** We follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. However, you won't pay for emergency services if you delay telling us. For more information call Member Services at **1-833-412-4405** (TTY: 711) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. You can find this information on the back of your Member ID 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. To learn more, refer to the Benefits Chart in **Chapter 4** of this *Member Handbook*.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

Our plan covers your follow-up care. If you get your emergency care from out-of-network providers, we'll try to get network providers to take over your care as soon as possible. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.

After the emergency is over, you may need follow-up care to be sure you get better. Your follow-up care will be covered by us. If you get your emergency care from out-of-network providers, we will try to get network providers to take over your care as soon as possible. If you need an ambulance to get to the emergency room, our plan covers that. We also cover medical services during the emergency. To learn more, refer to the Benefits Chart in **Chapter 4**.

Anthem I PathWays Dual Care Advantage (HMO D-SNP) offers limited supplemental emergency medical care coverage for occasions when you are outside of the United States. Please refer to the Benefits Chart in **Chapter 4** for more details.

Getting emergency care if it wasn't an emergency

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

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

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

12. Urgently needed care

Urgently needed care is care you get for a situation that isn't an emergency but needs care right away. For example, you might have a flare-up of an existing condition or an unforeseen illness or injury.

Urgently needed care in our plan's service area

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

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

If it's not possible or reasonable to get to a network provider, given your time, place or circumstances we cover urgently needed care you get from an out-of-network provider.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. Urgently needed service coverage is worldwide.

Anthem I PathWays Dual Care Advantage (HMO D-SNP) offers limited supplemental urgently needed services coverage for occasions when you are outside of the United States. Please refer to the Benefits Chart in **Chapter 4** for more details.

Urgently needed care outside our plan's service area

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

Our plan covers worldwide emergency and urgently needed care services outside the United States and its territories under the following circumstances. This plan covers emergency or urgently needed 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. \$0 copay for each covered worldwide urgent care visit, emergency ground transportation, or emergency room visit.

I3. Care during a disaster

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

Visit our website for information on how to get care you need during a declared disaster:
www.anthem.com.

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

J. What if you're billed directly for covered services

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

J1. What to do if our plan doesn't cover services

Our plan covers all services:

- that are determined medically necessary, **and**
- that are listed in our plan's Benefits Chart (refer to **Chapter 4** of this *Member Handbook*), **and**
- that you get by following plan rules.

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

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

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

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

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

K1. Definition of a clinical research study

In compliance with Section 210 of the *Consolidated Appropriations Act of 2021*, the Indiana Health Coverage Programs (IHCP) covers the routine costs of qualifying clinical trials to the extent that the item or service would otherwise be covered for the member when not participating in the qualifying clinical trial. This coverage includes any item or service provided to prevent, diagnose, monitor or treat complications resulting from participation. More information can be found at www.in.gov/medicaid/providers/files/modules/Clinical-Trials.pdf.

A clinical research study (also called a clinical trial) is a way doctors test new types of health care or drugs. A clinical research study approved by Medicare typically asks for volunteers to be in the study. 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 want to take part in any Medicare-approved clinical research study, you **don't** need to tell us or get approval from us or your primary medical provider. Providers that give you care as part of the study **don't** need to be network providers. This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

(NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.

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

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

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

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

- room and board for a hospital stay that Medicare would pay for even if you weren't in a study
- an operation or other medical procedure that's part of the research study
- treatment of any side effects and complications of the new care

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

K3. More about clinical research studies

You can learn more about joining a clinical research study by reading "Medicare & Clinical Research Studies" on the Medicare website (www.medicare.gov/coverage/clinical-research-studies). You can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

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

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

Services provided in a religious non-medical health care institution are provided within the limitations of 42 CFR 44017(b).

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

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



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

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

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

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

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

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

M. Durable medical equipment (DME)

M1. DME as a member of our plan

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

You always own some DME items, such as prosthetics.

Other types of DME you must rent. As a member of our plan, you usually **won't** own the rented DME items, no matter how long you rent it.

In some limited situations, we transfer ownership of the DME item to you. Call Member Services at the phone number at the bottom of the page for more information.



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

M2. DME ownership if you switch to Original Medicare

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

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

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

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

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

M3. Oxygen equipment benefits as a member of our plan

If you qualify for oxygen equipment covered by Medicare we cover:

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

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



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

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

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

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

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 4: Benefits chart

Introduction

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

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A. Your covered services

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

Because you get help from Indiana PathWays for Aging, you pay nothing for your covered services as long as you follow our plan's rules. Refer to **Chapter 3** of this *Member Handbook* for details about our plan's rules.

If you need help understanding what services are covered, call your care coordinator and/or Member Services at 1-833-412-4405 (TTY: 711) 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.

B. Rules against providers charging you for services

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

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

C. About our plan's Benefits Chart

The Benefits Chart tells you the services our plan pays for. (Drug coverage is in **Chapter 5**.) It lists covered services in alphabetical order and explains them.

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

- We provide covered Medicare and Indiana PathWays for Aging covered services according to the rules set by Medicare and Indiana PathWays for Aging.
- The services (including medical care, behavioral health and substance use services, long-term services and supports, supplies, equipment, and drugs) must be "medically necessary." Medically necessary describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.



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- For new enrollees, for the first 90 days we may not require you to get approval in advance for any active course of treatment, even if the course of treatment was for a service that began with an out-of-network provider.
- You get your care from a network provider. A network provider is a provider who works with us. In most cases, care you get from an out-of-network provider won't be covered unless it's an emergency or urgently needed 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. **Chapter 3** of this *Member Handbook* has more information about using network and out-of-network providers.
- You have a primary medical provider (PMP) or a care team providing and managing your care.
- Our health plan will ensure continuity of care and coordination of medically necessary health care services for new members. We'll honor previous care authorizations for one of the following durations, whichever comes first: ninety (90) calendar days from the member's date of enrollment with the Contractor, or the remainder of the prior authorized dates of service, or until the approved units of service are exhausted.
- We cover some services listed in the Benefits Chart only if your doctor or other network provider gets our approval first. This is called prior authorization (PA). We mark covered services in the Benefits Chart that need PA with a footnote.
- If our plan provides approval of a PA request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care based on coverage criteria, your medical history, and the treating provider's recommendations.
- Like all Medicare health plans, we cover everything that Original Medicare covers. (To learn more about the coverage and cost of Original Medicare, go to *Medicare & You 2027* 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.)
- If Medicare adds coverage for any new services during 2027, either Medicare or our plan will cover those services.
- If you lose your Indiana PathWays for Aging eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem I PathWays Dual Care Advantage (HMO D-SNP). When your Indiana PathWays for Aging coverage ends, we won't pay for your Indiana PathWays for Aging benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medicaid used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.

In addition, if you lose your Indiana PathWays for Aging eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

For additional information about how a change in your Indiana PathWays for Aging eligibility may affect your benefits and cost sharing, please contact Member Services.



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We'll assist you to regain your Indiana PathWays for Aging eligibility. If your Indiana PathWays for Aging eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Indiana PathWays for Aging benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and cost-sharing assistance for which you again qualify. If you can't regain Indiana PathWays for Aging within six months we'll disenroll you from Anthem I PathWays Dual Care Advantage (HMO D-SNP). If you regain Indiana PathWays for Aging eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

Important Benefit Information for Members with Certain 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:



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- o Polyarteritis nodosa,
 - o Polymyalgia rheumatica,
 - o Polymyositis,
 - o Dermatomyositis
 - o Rheumatoid arthritis,
 - o Systemic lupus erythematosus,
 - o Psoriatic arthritis, and
 - o Scleroderma;
- Cancer;
- Cardiovascular disorders:
 - o Cardiac arrhythmias,
 - o Coronary artery disease,
 - o Peripheral vascular disease, and
 - o Valvular heart disease;
- Chronic heart failure;
- Dementia;
- Diabetes mellitus;
 - o Pre-diabetes (Fasting blood glucose: 100-125 mg/dl or Hgb A1C:5.7-6.4%)
- Overweight, Obesity, and Metabolic Syndrome;
- Chronic gastrointestinal disease:
 - o Chronic liver disease,
 - o Non-alcoholic fatty liver disease (NAFLD),
 - o Hepatitis B,
 - o Hepatitis C,
 - o Pancreatitis,
 - o Irritable bowel syndrome, and
 - o Inflammatory bowel disease;



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- 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



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



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- o Paralysis,
- o Limb loss,
- o Stroke, and
- o 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
 - o Chronic hypertension
 - o Osteoporosis
 - o 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 (SSBCI) row in the Medical Benefits Chart below. Contact us to find out exactly which benefits you may be eligible for.

All preventive services are free. You will find this apple 🍏 next to preventive services in the Benefits Chart.

D. Our plan’s Benefits Chart

Covered Service		What you pay
	Abdominal aortic aneurysm screening We pay for a one-time ultrasound screening 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 (PA), nurse practitioner (NP), or clinical nurse specialist (CNS).	\$0

Covered Service	What you pay
Acupuncture We pay for up to 12 acupuncture visits in 90 days if you have chronic low back pain, defined as: • lasting 12 weeks or longer; • not specific (having no systemic cause that can be identified, such as not associated with metastatic, inflammatory, or infectious disease); • not associated with surgery; • not associated with pregnancy. In addition, we pay for an additional eight sessions of acupuncture for chronic low back pain if you show improvement. You may not get more than 20 acupuncture treatments for chronic low back pain each year. Acupuncture treatments must be stopped if you don't get better or if you get worse. Provider Requirements: Physicians may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs), 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. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Acupuncture (continued) <i>Talk to your provider to get a prior authorization.</i>	
 Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women. If you screen positive for alcohol misuse, you can get up to four brief, face-to-face counseling sessions each year (if you are able and alert during counseling) with a qualified primary medical provider (PMP) or practitioner in a primary care setting.	\$0
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include ground and air (airplane and helicopter), and ambulance services. The ambulance will take you to the nearest place that can give you care. Your condition must be serious enough that other ways of getting to a place of care could risk your health or life. Ambulance services for other cases (non-emergent) must be approved by us. In cases that aren't emergencies, we may pay for an ambulance. Your condition must be serious enough that other ways of getting to a place of care could risk your life or health. <i>Talk to your provider to get a prior authorization.</i>	\$0
Annual routine physical exam - Supplemental In addition to the “Welcome to Medicare” exam or the annual wellness visit, you are covered for one routine physical exam each year. The routine physical includes a comprehensive examination and evaluation of your health status and chronic diseases.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
 Annual wellness visit You can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. We pay for this once every 12 months. Note: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare visit. However, you don't need to have had a Welcome to Medicare visit to get annual wellness visits after you've had Part B for 12 months.	\$0
 Bone mass measurement We pay for certain procedures for members who qualify (usually, someone at risk of losing bone mass or at risk of osteoporosis). These procedures identify bone mass, find bone loss, or find out bone quality. We pay for the services once every 24 months, or more often if medically necessary. We also pay for a doctor to look at and comment on the results.	\$0
 Breast cancer screening (mammograms) We pay for the following services: • one baseline mammogram between the ages of 35 and 39 • one screening mammogram every 12 months for women aged 40 and over • clinical breast exams once every 24 months	\$0
Cardiac (heart) rehabilitation services We pay for cardiac rehabilitation services such as exercise, education, and counseling. Members must meet certain conditions and have a doctor's order. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months This benefit continues on the next page.	\$0



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Covered Service	What you pay
Cardiac (heart) rehabilitation services (continued) • coronary artery bypass surgery • stable angina pectoris (chest pain) • heart valve repair or replacement • coronary angioplasty (a medical procedure used to open a blocked artery) or coronary stenting (a procedure used to keep an artery open) • heart or heart and lung transplant • stable chronic heart failure Coverage limitations: You can get up to 36 cardiac rehabilitation sessions. You can have two sessions per day (each lasting one hour), and the program can last up to 36 weeks. If you qualify, you may be able to get 36 more sessions that can be spread out over a longer time period. <i>Talk to your provider to get a prior authorization.</i>	
 Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary medical provider (PMP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, and/or • give you tips to make sure you are eating well.	\$0
 Cardiovascular (heart) disease screening tests We pay for blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.	\$0



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Covered Service	What you pay
Caregiver Way Membership - Enhanced Service Eligible members or their caregivers can receive a membership voucher to access the Caregiver Way social platform to connect with other resources for education, support and guidance on how to tend to the needs of a member. <i>No eligibility or benefit limits</i>	\$0
 Cervical and vaginal cancer screening We pay for the following services: • for all women: Pap tests and pelvic exams once every 24 months • for women who are at high risk of cervical or vaginal cancer: one Pap test every 12 months • for women who have had an abnormal Pap test within the last three years and are of childbearing age: one Pap test every 12 months	\$0
Chiropractic services We pay for the following services: • adjustments of the spine to correct alignment Our plan includes covered services provided by a licensed chiropractor when rendered within the scope of the practice of chiropractic. Limited to five visits and 50 therapeutic physical medicine treatments per member per year <i>Talk to your provider to get a prior authorization.</i>	\$0
 Colorectal cancer screening We pay for the following services: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (ten years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk This benefit continues on the next page.	\$0



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Covered Service	What you pay
 Colorectal cancer screening (continued) for colorectal cancer, and once every 24 months for high risk patients after a previous screening colonoscopy. • Computed tomography colonography for patients 45 years and older who aren't at high risk of colorectal cancer is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed, or when 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment 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 got a screening colonoscopy. Once every 48 months for high risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high risk criteria. Once every three years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. • Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter or other This benefit continues on the next page.	



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Covered Service	What you pay
 Colorectal cancer screening (continued) procedure furnished in connection with, as result of, and in the same clinical encounter as the screening test.	
Companion Connect - Enhanced Service Eligible members receive a set of two voice-activated smart speakers with video calling capability: one for the member in the nursing facility and one for a loved one. Members who live in a nursing facility with a long-term level of care are eligible. This is only applicable if residing in a Nursing Facility. <i>One set per member per lifetime.</i>	\$0
COPD Relief Product - Enhanced Service Eligible members may select one product from a catalog of options, such as: a travel nebulizer, hypoallergenic bedding, HEPA air filter, and more. Members who are diagnosed with COPD are eligible. <i>One item per member per year.</i>	\$0



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Covered Service	What you pay
Dental Services We pay for some dental services when the service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. <i>Talk to your provider to get a prior authorization.</i>	\$0
Dental Services - Supplemental This plan provides additional dental coverage not covered by Original Medicare. This plan covers up to a \$2,500 allowance for covered preventive and comprehensive dental services every year. 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: This benefit continues on the next page.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Dental Services - Supplemental (continued) • 2 Exams • 2 X-rays • 2 Cleanings • 2 Fluoride treatments • Other preventive services (treatment to prevent oral disease and stop tooth decay) • Other diagnostic services (specialized X-rays) Comprehensive Dental Services: • Restorative (fillings, crowns and related tooth restoration services) • 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, denture repairs, and related services) • Oral and Maxillofacial Surgery (teeth extractions, surgical repairs, and other related specialized procedures) • Limited Implant maintenance and repair services • Limited Orthodontic treatment • Adjunctive General Services (emergency treatment, sedation, anesthesia, night guards) Please note: • Prior authorization is required for restorative crowns, bridges, some denture, some oral and maxillofacial surgery, and orthodontic services prior to treatment being This benefit continues on the next page.	



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Covered Service	What you pay
Dental Services - Supplemental (continued) performed. Services must meet our clinical criteria and guidelines to be approved and covered. • Other dental services are subject to limitations. • 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. For detailed information on prior authorization, limitations, and exclusions, please refer to the supplemental dental section immediately following this Medical Benefits Chart.	
 Depression screening We pay for one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and/or referrals.	\$0
 Diabetes screening We pay for this screening (includes fasting glucose tests) if you have any of the following risk factors: • high blood pressure (hypertension) • history of abnormal cholesterol and triglyceride levels (dyslipidemia) • obesity • history of high blood sugar (glucose) Tests may be covered in some other cases, such as if you are overweight and have a family history of diabetes. You may qualify for up two diabetes screenings every 12 months following the date of your most recent diabetes screening test.	\$0



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Covered Service	What you pay
 Diabetic self-management training, services, and supplies We pay for the following services for all people who have diabetes (whether they use insulin or not): - Supplies to monitor your blood glucose, including the following: - a blood glucose monitor - blood glucose test strips - lancet devices and lancets - glucose-control solutions for checking the accuracy of test strips and monitors - For people with diabetes who have severe diabetic foot disease, we pay for the following: - one pair of therapeutic custom-molded shoes (including inserts), including the fitting, and two extra pairs of inserts each calendar year, or - one pair of depth shoes, including the fitting, and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes) - In some cases, we pay for training to help you manage your diabetes. To find out more, contact Member Services. Blood Glucose Monitors and Supplies: This plan covers one blood glucose monitor every calendar year. Test strips are covered for 102 units every 30 days and up to 306 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. If you are using a brand of diabetic test strips that is not covered by our plan, we will continue to cover it for up to two fills during This benefit is continued on the next page	\$0



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Covered Service	What you pay
 Diabetic self-management training, services, and supplies (continued) the first 90 days after joining our plan. During this time, talk with your doctor to decide what brand is medically best for you. 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: Lancets are covered for 100 units every 30 days and up to 300 units for a 90-day supply. 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. During this time, talk with your doctor to decide what brand is medically best for you. Continuous Glucose Monitors (CGMs): 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 This benefit is continued on the next page	



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Covered Service	What you pay
 Diabetic self-management training, services, and supplies (continued) other brands unless your provider tells us it is medically necessary. CGMs MUST be purchased at a network retail or our mail-order pharmacy to be covered. If you purchase these supplies through a Durable Medical Equipment (DME) provider, these items will not be covered. Coverage limitations: • 2-3 sensors per month depending on the receiver • One receiver every 2 years Insulin pumps: Insulin pumps are different than a CGM and can be purchased through a DME provider or at a network pharmacy. <i>Talk to your provider to get a prior authorization.</i>	
Digital Mental Health Toolkit - Enhanced Service Eligible members receive unlimited access to an online community which promotes behavioral health and wellness through instruction, coaching, goal setting and monitoring. <i>No eligibility or benefit limits</i>	\$0
Durable medical equipment (DME) and related supplies Refer to Chapter 12 of this <i>Member Handbook</i> for a definition of “Durable medical equipment (DME).” We cover the following items: • wheelchairs • crutches • powered mattress systems • diabetic supplies This benefit is continued on the next page.	\$0 Your cost-sharing won't change after being enrolled for 36 months.



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Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment Other items may be covered. We pay for all medically necessary DME that Medicare and Medicaid usually pay for. If our supplier in your area doesn't carry a particular brand or maker, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at www.anthem.com. 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. 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. You must get durable medical equipment through our approved suppliers. You cannot purchase these items from a pharmacy. <i>Talk to your provider to get a prior authorization.</i>	



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Covered Service	What you pay
Emergency Care Emergency care means services that are: • given by a provider trained to give emergency services, • needed to evaluate or treat a medical emergency. A medical emergency is an illness, injury, severe pain, or medical condition that's quickly getting worse. The condition is so serious that, if it doesn't get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in: • serious risk to your life or to that of your unborn child; or • serious harm to bodily functions; or • loss of a limb, or loss of function of a limb. • In the case of a pregnant woman in active labor, when: - o There isn't enough time to safely transfer you to another hospital before delivery. - o A transfer to another hospital may pose a threat to your health or safety or to that of your unborn child. Emergency care coverage is worldwide. This 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. Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.	\$0 If you get emergency care at an out-of-network hospital and need inpatient care after your emergency is stabilized, you must move to a network hospital for your care to continue to be paid for. You can stay in the out-of-network hospital for your inpatient care only if our plan approves your stay.



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Covered Service	What you pay
Everyday Options Allowance - Supplemental This benefit provides a combined spending allowance of \$305 every month on your Benefits Prepaid Card. This spending allowance can be used to pay for: - Assistive and safety devices like ADA toilet seats, shower stools, hand-held shower heads, reaching devices, temporary wheelchair threshold ramps, and more - OTC products like vitamins, first aid supplies, pain-relievers, and more If you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), you may also be able to use this allowance on: - 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 This benefit is continued on the next page	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Everyday Options Allowance - Supplemental (continued) ○ 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 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. Some items such as candy, sodas, certain snack foods and prepared desserts are also excluded. • 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.	



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Covered Service	What you pay
Family planning services The law lets you choose any provider – whether a network provider or out-of-network provider – for certain family planning services. This means any doctor, clinic, hospital, pharmacy or family planning office. We pay for the following services: • family planning exam and medical treatment • family planning lab and diagnostic tests • family planning methods (IUC/IUD, implants, injections, birth control pills, patch, or ring) • family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap) • counseling and diagnosis of infertility and related services • counseling, testing, and treatment for sexually transmitted infections (STIs) • counseling and testing for HIV and AIDS, and other HIV-related conditions • permanent contraception (You must be age 21 or over to choose this method of family planning. You must sign a federal sterilization consent form at least 30 days, but not more than 180 days before the date of surgery.) • genetic counseling We also pay for some other family planning services. However, you must use a provider in our provider network for the following services: • treatment for medical conditions of infertility (This service doesn't include artificial ways to become pregnant.) • treatment for AIDS and other HIV-related conditions • genetic testing	\$0
Fresh Food Connect - Enhanced Service Eligible members can select one of the following options: This benefit continues on the next page.	\$0



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Covered Service	What you pay
Fresh Food Connect - Enhanced Service (continued) • 10 fresh ready-to-cook meals • Two fresh produce boxes, or • Online grocery delivery Members who already receive meals through a waiver program or a residential facility are not eligible for this benefit. <i>One selection per member per year</i>	
 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	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Healthy Lifestyle Aid - Enhanced Service Eligible members may select one item from a custom catalog of lifestyle aids, such as: a blood pressure cuff, digital thermometer, pulse oximeter, digital scale, and more. Members who are diagnosed with hypertension, diabetes, congestive heart failure, or coronary artery disease are eligible. <i>One item per member per year.</i>	\$0



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Covered Service	What you pay
Healthy Meals - Post-discharge - Supplemental This plan covers up to 2 meals a day for 10 days (maximum 20 meals) following your discharge from the hospital or skilled nursing facility (SNF). 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 Member Services 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.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Hearing services We pay for hearing and balance tests done by your provider. These tests tell you whether you need medical treatment. They're covered as outpatient care when you get them from a physician, audiologist, or other qualified provider. <i>Talk to your provider to get a prior authorization.</i>	\$0
Hearing services - Supplemental 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 This benefit is continued on the next page	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Hearing services - Supplemental (continued) \$2,000 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. Hearing aids are limited to specific devices based on your hearing needs. <i>Talk to your provider to get a prior authorization.</i>	
 HIV screening We pay for one HIV screening exam every 12 months for people who: - ask for an HIV screening test, or - are at increased risk for HIV infection. If you are pregnant, we pay for up to three HIV screening tests during a pregnancy.	\$0



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Covered Service	What you pay
Home Based Palliative Care - Enhanced Service Aspire is a home-based palliative care service that treats members with advanced illnesses who are estimated to be in their last year of life, and at high risk for high utilization rates. Eligible members have an advanced illness, are estimated to be in their last year of life, and are at high-risk of substantial healthcare utilization. <i>No benefit limits. Care Management referral required</i>	\$0
Home Essentials - Enhanced Service Members transitioning to a community setting may select one of the following options to support the purchase of home goods and other essentials: • Thrift store gift card • Walmart gift card OR • One item from a custom-curated catalog <i>No eligibility limits. One selection per member per year</i>	\$0
Home Fitness Kit - Enhanced Service Eligible members receive unlimited access to online fitness and exercise videos, and one at-home fitness kit. <i>No eligibility limits. One kit per member per year</i>	\$0
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: This benefit continues on the next page.	\$0



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Covered Service	What you pay
Home health agency care (continued) - part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than eight hours per day and 35 hours per week.) - physical therapy, occupational therapy, and speech therapy - medical and social services - medical equipment and supplies <i>Talk to your provider to get a prior authorization.</i>	
Home infusion therapy Our plan pays for home infusion therapy, defined as drugs or biological substances administered into a vein or applied under the skin and provided to you at home. The following are needed to perform home infusion: - the drug or biological substance, such as an antiviral or immune globulin; - equipment, such as a pump; and - supplies, such as tubing or a catheter. Our plan covers home infusion services that include but aren't limited to: - professional services, including nursing services, provided in accordance with your care plan; - member training and education not already included in the DME benefit; - remote monitoring; and - monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Home infusion therapy (continued) Separately from the Home Infusion Therapy Professional services, Home Infusion requires a Durable Medical Equipment component: • Durable Medical Equipment - the external infusion pump, the related supplies and the infusion drug(s), pharmacy services, delivery, equipment set up, maintenance of rented equipment, and training and education on the use of the covered items. <i>Talk to your provider to get a prior authorization.</i>	
Home Safety - Enhanced Service Members can choose one safety item from a custom-curated catalog of home safety items to fit their personal home needs, such as: mold test kit, fire extinguisher, smoke alarm, or a medication lock box. <i>One item per member per year</i>	\$0
Hospice care You have the right to elect hospice if your provider and hospice medical director determine you have a terminal prognosis. This means you have a terminal illness and are expected to have six months or less to live. You can get care from any hospice program certified by Medicare. Our plan must help you find Medicare-certified hospice programs in the plan's service area, including programs 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 to treat symptoms and pain • short-term respite care • home care This benefit continues on the next page.	\$0



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Covered Service	What you pay
Hospice care (continued) For hospice services and services covered by Medicare Part A or Medicare Part B that relate to your terminal prognosis are billed to Medicare. - Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A or B services related to your terminal illness. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. For services covered by our plan but not covered by Medicare Part A or Medicare Part B: - Our plan covers services not covered under Medicare Part A or Medicare Part B. We cover the services whether or not they relate to your terminal prognosis. You pay nothing for these services. For drugs that may be covered by our plan's Medicare Part D benefit: - Drugs are never covered by both hospice and our plan at the same time. For more information, refer to Chapter 5 of this Member Handbook. When you're admitted to a hospice, you have the right to stay in our plan. Note: If you need non-hospice care, call your care coordinator and/or member services to arrange the services. Non-hospice care is care that isn't related to your terminal prognosis. Our plan covers hospice consultation services (one time only) for a terminally ill member who has not chosen the hospice benefit.	
 Immunizations We pay for the following services: pneumonia vaccines This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Immunizations (continued) - flu/influenza shots, once each flu/influenza season in the fall and winter, with additional flu/influenza shots if medically necessary - hepatitis B vaccines if you've never received a complete series, you don't know your vaccination history, or you have any other condition that puts you 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 pay for other vaccines that meet the Medicare Part D coverage rules. Refer to Chapter 6 of this <i>Member Handbook</i> to learn more.	
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospital and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. We pay for the following services and other medically necessary services not listed here: - semi-private room (or a private room if medically necessary) - meals, including special diets - regular nursing services - costs of special care units, such as intensive care or coronary care units - drugs and medications - lab tests This benefit continues on the next page.	\$0 You must get approval from our plan to get inpatient care at an out-of-network hospital after your emergency is stabilized.



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Covered Service	What you pay
Inpatient hospital care (continued) • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse services • inpatient substance use disorders and inpatient psychiatric services • in some cases, the following types of transplants: corneal, kidney, kidney/pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then you can get your transplant services locally or outside the pattern of care for your community. If our plan provides transplant services outside the pattern of care for our community and you choose to get your transplant there, we arrange or pay for lodging and travel costs for you and one other person. The reimbursement for transportation costs are while you and your companion are traveling to and from the medical providers for services related to the transplant care. The plan defines the distant location as a location that is outside of the member's service area AND a minimum of 75 miles from the member's home. For each travel and lodging reimbursement request, please submit a letter from the Medicare-approved transplant center indicating the dates you were an inpatient of the Medicare-approved transplant center, and the dates you were treated as an outpatient when required to be near the Medicare-approved transplant center to receive This benefit continues on the next page.	



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Covered Service	What you pay
Inpatient hospital care (continued) treatment/services related to the transplant care. Please also include documentation of any companion and the dates they traveled with you while you were receiving services related to the transplant care. Travel reimbursement forms can be requested from Member Services. Transportation and lodging costs will be reimbursed for travel mileage and lodging consistent with current IRS travel mileage and lodging guidelines on the date services are rendered. Accommodations for lodging will be reimbursed at the lesser of: 1) billed charges, or 2) consistent with IRS guidelines for maximum lodging for that location. You can access current reimbursement on the US General Services Administration website www.gsa.gov. All requests for reimbursement must be submitted within one year (12 months) from the date incurred. For more information on how and where to submit a claim, please go to Chapter 7. • blood, including storage and administration . Coverage of whole blood and packed red cells starts only with the fourth pint of blood you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered starting with the first pint. • physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefit</i> available at Medicare.gov/publications/1435-Medicare-HospitalBenefits.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. <i>Talk to your provider to get a prior authorization.</i>	



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Covered Service	What you pay
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. If you're admitted to a State psychiatric hospital, you'll be disenrolled from our plan. • There is a 190-day lifetime limit for inpatient services in a freestanding psychiatric hospital. ◦ The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. Your provider must get an approval from the plan before you are admitted to a hospital for a mental condition, drug or alcohol abuse or rehab. <i>Talk to your provider to get a prior authorization.</i>	\$0
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay We don't pay for your inpatient stay if you've used all of your inpatient benefit or if the stay isn't reasonable and medically necessary. However, in certain situations where inpatient care isn't covered, we may pay for services you get while you're in a hospital or nursing facility. To find out more, contact Member Services. We pay for the following services, and maybe other services not listed here: • doctor 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 for fractures and dislocations This benefit continues on the next page.	\$0



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Covered Service	What you pay
Inpatient stay: Covered services in a hospital or skilled nursing facility (SNF) during a non-covered inpatient stay (continued) - prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: - an internal body organ (including contiguous tissue), or - the function of an inoperative or malfunctioning internal body organ. - leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in your condition - physical therapy, speech therapy, and occupational therapy <i>Talk to your provider to get a prior authorization.</i>	
Kidney disease services and supplies We pay for the following services: - Kidney disease education services to teach kidney care and help you make good decisions about your care. You must have stage IV chronic kidney disease, and your doctor must refer you. We cover up to six sessions of kidney disease education services. - Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area, as explained in Chapter 3 of your <i>Member Handbook</i>, or when your provider for this service is temporarily unavailable or inaccessible. - Inpatient dialysis treatments if you're admitted as an inpatient to a hospital for special care - Self-dialysis training, including training for you and anyone helping you with your home dialysis treatments This benefit continues on the next page.	\$0



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Covered Service	What you pay
Kidney disease services and supplies (continued) • Home dialysis equipment and supplies • Certain home support services, such as necessary visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply. Medicare Part B pays for some drugs for dialysis. For information, refer to “Medicare Part B drugs” in this chart. 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.	
Legend drugs Refer to Chapter 12 of this <i>Member Handbook</i> for a definition of “Legend Drugs.” Medicaid covers legend drugs if the drug is: • a written prescription by your doctor; • approved by the United States Food and Drug Administration (FDA); • not designated by CMS as less than effective or identical, related, or similar to a less than effective drug; and • not specifically excluded from coverage by Indiana Medicaid.	
Long Term Services and Supports (LTSS) Waiver Services For eligible PathWays members the following waiver services are covered: • Adult Day Service • Attendant Care • Caregiver Coaching • Home and Community Assistance This benefit continues on the next page.	



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Covered Service	What you pay
Long Term Services and Supports (LTSS) Waiver Services (continued) • Respite • Community Home Share Assisted Living • Community Transition • Home Delivered Meals • Home Modification Assessment • Home Modifications • Integrated Health Care Coordination • Nutritional Supplements • Self-Directed Services • Personal Emergency Response System • Pest Control • Specialized Medical Equipment and Supplies • Structured Family Caregiving • Transportation • Vehicle Modifications If you gain LTSS waiver eligibility during the year, you'll be able to get these services.	
 Lung cancer screening with low dose computer tomography (LDCT) Our plan pays for lung cancer screening every 12 months if you: • are aged 50-77, and • have a counseling and shared decision-making visit with your doctor or other qualified provider, and • have smoked at least one pack a day for 20 years with no signs or symptoms of lung cancer or smoke now or have quit within the last 15 years After the first screening, our plan pays for another screening each year with a written order from your doctor or other qualified This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Lung cancer screening with low dose computed tomography (LDCT) (continued) provider. If a provider elects to provide a lung cancer screening counseling and shared decision-making visit for lung cancer screenings, the visit must meet the Medicare criteria for such visits.	
 Medical nutrition therapy This benefit is for people with diabetes or kidney disease without dialysis. It's also for after a kidney transplant when ordered by your doctor. We pay for three hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare. We may approve additional services if medically necessary. We pay for two hours of one-on-one counseling services each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a doctor's order. A doctor must prescribe these services and renew the order each year if you need treatment in the next calendar year. We may approve additional services if medically necessary.	\$0
 Medicare Diabetes Prevention Program (MDPP) Our plan pays for MDPP services for eligible people. MDPP is designed to help you increase healthy behavior. It provides practical training in: • long-term dietary change, and • increased physical activity, and • ways to maintain weight loss and a healthy lifestyle.	\$0



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Covered Service	What you pay
Medicare Part B drugs These drugs are covered under Part B of Medicare. Our plan pays for the following drugs: • drugs you don't usually give yourself and are injected or infused while you get doctor, hospital outpatient, or ambulatory surgery center services • insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump) • other drugs you take using durable medical equipment (such as nebulizers) that our plan authorized • the Alzheimer's drug, Leqembi® (generic lecanemab) which is given intravenously (IV). In addition to medication costs, you may need additional scans and tests before and/or during treatment. 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 covers immunosuppressive drugs if Part B does not cover them • osteoporosis drugs that are injected. We pay for these drugs if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug yourself • 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 This benefit continues on the next page.	\$0



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Covered Service	What you pay
Medicare Part B drugs (continued) the same active ingredient found in 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 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-epotin beta) - IV immune globulin for the home treatment of primary immune deficiency diseases - parenteral and enteral nutrition (IV and tube feeding) 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. Some of the Part B covered drugs listed above may be subject to step therapy. The following link takes you to a list of Medicare Part B drugs that may be subject to step therapy: https://shop.anthem.com/medicare. Enter your ZIP code, and select Plan Documents. Then This benefit continues on the next page.	



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Covered Service	What you pay
Medicare Part B drugs (continued) click Prescription Drug Coverage Details and choose Part B Step Therapy from the list. We also cover some vaccines under our Medicare Part B and most adult vaccines under our Medicare 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 of this <i>Member Handbook</i> explains our drug benefit. It explains rules you must follow to have prescriptions covered. Chapter 6 of this <i>Member Handbook</i> explains what you pay for your drugs through our plan. <i>Talk to your provider to get a prior authorization.</i>	
Non-Emergency medical transportation Our plan covers non-emergency medical transportation when another alternative isn't available. See the Transportation – Supplemental category below for information on how to obtain supplemental transportation services.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
24/7 Nurseline - Supplemental 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.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Nursing facility care A nursing facility (NF) is a place that provides care for people who can't get care at home but who don't need to be in a hospital. Our plan covers both short and long-term stays which includes the following services. • short-term stays, those less than 30 calendar days • long-term stays, those greater than 30 calendar days require pre-admission screening for level of care determination Services that we pay for include, but aren't limited to, the following: • semiprivate room (or a private room if medically necessary) • meals, including special diets • nursing services • physical therapy, occupational therapy, and speech therapy • respiratory therapy • drugs given to you as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.) • blood, including storage and administration • medical and surgical supplies usually given by nursing facilities • lab tests usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities • X-rays and other radiology services usually given by nursing facilities • physician/practitioner services • durable medical equipment • dental services, including dentures This benefit continues on the next page.	\$0



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Covered Service	What you pay
Nursing facility care (continued) • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you were living right before you went to the hospital (as long as it provides nursing facility care). • a nursing facility where your spouse or domestic partner is living at the time you leave the hospital.	
 Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary medical provider to find out more.	\$0
Opioid treatment program (OTP) services Our plan pays for the following services to treat opioid use disorder (OUD) through an OTP which includes the following services: • intake activities • periodic assessments • medications approved by the FDA and, if applicable, managing and giving you these medications • substance use disorder counseling • individual and group therapy This benefit continues on the next page.	\$0



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Covered Service	What you pay
Opioid treatment program (OTP) services (continued) • testing for drugs or chemicals in your body (toxicology testing) <i>Talk to your provider, you may need a prior authorization.</i>	
Outpatient diagnostic tests and therapeutic services and supplies We pay for the following services and other medically necessary services not listed here: • X-rays • radiation (radium and isotope) therapy, including technician materials and supplies • surgical supplies, such as dressings • splints, casts, and other devices used for fractures and dislocations • lab tests • blood, including storage and administration • 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 condition • 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. <i>Talk to your provider to get a prior authorization.</i>	\$0
Outpatient hospital observation We pay for outpatient hospital observation services to determine if you need to be admitted as an inpatient or can be discharged. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Outpatient hospital observation (continued) The services 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 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. 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 hospital staff. Get more information from the Medicare fact sheet <i>Medicare Hospital Benefits</i> available at Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf <i>Talk to your provider to get a prior authorization.</i>	
Outpatient hospital services We pay for medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury, such as: • Services in an emergency department or outpatient clinic, such as outpatient surgery or observation services • Labs and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Some drugs and biologicals that you can't give yourself <i>Talk to your provider to get a prior authorization.</i>	\$0
Outpatient mental health care We pay for mental health services provided by: This benefit continues on the next page.	\$0



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Covered Service	What you pay
Outpatient mental health care (continued) • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (CSW) • a clinical nurse specialist (CNS) • a licensed professional counselor (LPC) • a licensed marriage and family therapist (LMFT) • a nurse practitioner (NP) • a physician assistant (PA) • any other Medicare-qualified mental health care professional as allowed under applicable state laws <i>Talk to your provider, you may need a prior authorization.</i>	
Outpatient rehabilitation services We pay for physical therapy, occupational therapy, and speech therapy. You can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities. <i>Talk to your provider to get a prior authorization.</i>	\$0
Outpatient substance use disorder services We pay for the following services, and maybe other services not listed here: • alcohol misuse screening and counseling • treatment of drug abuse • group or individual counseling by a qualified clinician • subacute detoxification in a residential addiction program • alcohol and/or drug services in an intensive outpatient treatment center This benefit continues on the next page.	\$0



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Covered Service	What you pay
Outpatient substance use disorder services (continued) extended-release Naltrexone (vivitrol) treatment <i>Talk to your provider, you may need a prior authorization.</i>	
Outpatient surgery We pay for outpatient surgery and services 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. Even if you stay in the hospital overnight, you might still be considered an outpatient. <i>Talk to your provider to get a prior authorization.</i>	\$0
Over-the-counter drugs Our plan covers certain over-the-counter drugs on our <i>List of Covered Drugs</i> (formulary).	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Partial hospitalization services and intensive outpatient services Partial hospitalization is a structured program of active psychiatric treatment. It's offered as a hospital outpatient service or by a community mental health center that's more intense than the care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office. It can help keep you from having to stay in the hospital. Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided as a hospital outpatient service, a community mental health center, a This benefit continues on the next page.	\$0



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Covered Service	What you pay
Partial hospitalization services and intensive outpatient services (continued) Federally qualified health center, or a rural health clinic that is more intense than the care received in your doctor's, therapists, LMFT, or licensed professional counselor's office but less intense than partial hospitalization. Note: Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	
Personal Emergency Response System (PERS) - Supplemental Coverage of one personal emergency response system and monthly monitoring in the member's home when arranged by the plan with a contracted vendor. The Personal Emergency Response System benefit provides an in-home device to notify appropriate personnel of an emergency (e.g., a fall). Please call Member Services for more information or to request the device.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Physician/provider services, including doctor's office visits We pay for the following services: - medically necessary health care or surgery services given in places such as: - physician's office - certified ambulatory surgical center - hospital outpatient department - any other location - consultation, diagnosis, and treatment by a specialist - basic hearing and balance exams given by your primary medical provider or specialist, if your doctor orders them to find out whether you need treatment This benefit continues on the next page.	\$0



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) - 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 get one of these services by telehealth, you must use a network provider who offers the service by telehealth. - Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, for members in certain rural areas or other places approved by Medicare - telehealth services for monthly end-stage renal disease (ESRD) related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or at home - telehealth services to diagnose, evaluate, or treat symptoms of a stroke - telehealth services for members with a substance use disorder or co-occurring mental health disorder regardless of your location - telehealth services for diagnosis, evaluation, and treatment of mental health disorders - 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 five-ten minutes if - you're not a new patient and - the check-in isn't related to an office visit in the past seven days and This benefit continues on the next page.	



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Covered Service	What you pay
Physician/provider services, including doctor's office visits (continued) - o the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment • Evaluation of video and/or images you send to your doctor and interpretation and follow-up by your doctor within 24 hours if: - o you're not a new patient and - o the evaluation isn't related to an office visit in the past seven days and - o the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment • Consultation your doctor has with other doctors by phone, the Internet, or electronic health record if you're not a new patient • Second opinion by another network provider before surgery <i>Talk to your provider to get a prior authorization.</i>	
Podiatry services We pay for the following services: • diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs) • routine foot care for members with conditions affecting the legs, such as diabetes • no more than six routine foot care visits per year for patients with a systemic disease of sufficient severity that unskilled performance of such procedure would be hazardous; and has resulted in severe circulatory embarrassment or areas of desensitization in the legs or feet. Proof must be submitted of patient visit to a medical doctor or doctor of osteopathy for treatment or evaluation This benefit continues on the next page.	\$0



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Covered Service	What you pay
Podiatry services (continued) of the systemic disease during the six month period prior to the rendering of routine foot care services. • Inpatient hospital stays and fitting or supplying of orthopedic shoes for patients with severe diabetic foot disease. Prior authorization is required	
Podiatry services - Supplemental This plan covers additional foot care services not covered by Original Medicare: • Removal or cutting of corns or calluses, trimming nails and other hygienic and preventive care in the absence of localized illness, injury, or symptoms involving the feet. • Unlimited routine foot care visits each year. <i>Talk to your provider to get a prior authorization.</i>	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
 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 including the fee for injecting the drug, if applicable • Up to eight individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to eight HIV screenings every 12 months. • A one-time hepatitis B virus screening.	\$0



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Covered Service	What you pay
 Prostate cancer screening exams For men age 50 and over, we pay for the following services once every 12 months: • a digital rectal exam • a prostate specific antigen (PSA) test	\$0
Prosthetic and orthotic devices and related supplies Prosthetic devices 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 • colostomy bags and supplies related to colostomy care • pacemakers • braces • prosthetic shoes • artificial arms and legs • breast prostheses (including a surgical brassiere after a mastectomy) We pay for some supplies related to prosthetic and orthotic devices. We also pay to repair or replace prosthetic and orthotic devices. We offer some coverage after cataract removal or cataract surgery. Refer to “Vision care” later in this chart for details. You must get prosthetic devices and supplies from a medical supply (DME) provider who works with this plan. They will not be covered if you buy them from a pharmacy. If you get a prosthetic or orthotic device while you are getting inpatient services at a hospital or skilled nursing facility, the cost will be included in your inpatient claim. <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
Pulmonary rehabilitation services We pay for pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). You must have an order for pulmonary rehabilitation from the doctor or provider treating the COPD. <i>Talk to your provider to get a prior authorization.</i>	\$0
Recuperative Care - Enhanced Service Provides medical respite care for members experiencing homelessness or unstable housing, scheduled or receiving medical care and need a safe place to recuperate. The program is available to members throughout the state. Members must meet criteria of experiencing homelessness or unstable housing, high utilizer of emergent or inpatient health care services, and must be scheduled or receiving medical care and needing a safe place to recuperate. <i>No benefit limits.</i>	\$0
Remote Patient Monitoring - Enhanced Service Eligible members will receive vital monitoring devices to manage their health through remote patient monitoring to have earlier intervention for any changes in health status, reducing the risk of hospital and emergency room visits. Members diagnosed with heart failure, diabetes, COPD, chronic kidney disease, or hypertension, or at-risk of inpatient and ER visits, and who agree to participate in the program. <i>No benefit limits.</i>	\$0



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Covered Service	What you pay
 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 pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	\$0
Sensory Solutions - Enhanced Service Members may receive a \$75 gift card for potential products such as a fidget spinner, puzzles, essential oils, weighted blankets, and more. <i>Members who are diagnosed with Alzheimer's disease, dementia, or autism are eligible.</i> <i>One card per member per year</i>	\$0
 Sexually transmitted infections (STIs) screening and counseling We pay for screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant women and for some people who are at increased risk for an STI. A primary medical provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Sexually transmitted infections (STIs) screening and counseling (continued) if given by a primary medical provider. The sessions must be in a primary care setting, such as a doctor's office.	
SilverSneakers – Supplemental 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 locations¹. You have access to a nationwide network of participating locations where you can take classes² and use exercise equipment and other amenities. Enroll in as many locations as you like, at any time. You also have access to instructors who lead specially designed group exercise classes in-person and online, seven days a week. Additionally, SilverSneakers Community gives you options to get active 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 location ("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. This benefit continues on the next page.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
SilverSneakers – Supplemental (continued) 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 trademarks of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to Chapter 12. Our plan covers both short and long-term stays which includes the following services. • short-term stays, those less than 30 calendar days. • long-term stays, those greater than 30 calendar days require pre-admission screening for level of care determination We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it is medically necessary • meals, including special diets • skilled nursing services • physical therapy, occupational therapy, and speech therapy • drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors • blood, including storage and administration • medical and surgical supplies given by SNFs • lab tests given by SNFs This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services You usually get SNF care from network facilities. Under certain conditions you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing facility or continuing care retirement community where you lived before you went to the hospital (as long as it provides nursing facility care) • a nursing facility where your spouse or domestic partner lives at the time you leave the hospital <i>Talk to your provider to get a prior authorization.</i>	
 Smoking and tobacco use cessation Counseling to quit smoking and tobacco use is covered on an outpatient and hospitalized basis for people who meet these criteria: • use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease • are competent and alert during counseling • a qualified physician or other Medicare-recognized practitioner provides counseling We cover two quit attempts per year (each attempt may include a maximum of four intermediate or intensive sessions, with up to eight sessions per year). Providers must perform tobacco dependence counseling for a minimum of 30 minutes (two units) and a maximum of 150 minutes (ten units) within the course of treatment	\$0



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Covered Service	What you pay
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 C of this chapter. Everyday Options Allowance: The following benefits are part of the Everyday Options Allowance. • Healthy Foods* • Utilities* *Please refer to the Everyday Options Allowance section in this chart for more information.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Supervised exercise therapy (SET) We pay for SET for members with symptomatic peripheral artery disease (PAD). Our plan pays for: • up to 36 sessions during a 12-week period if all SET requirements are met • an additional 36 sessions over time if deemed medically necessary by a health care provider The SET program must be: • 30 to 60-minute sessions of a therapeutic exercise-training program for PAD in members with leg cramping due to poor blood flow (claudication) • in a hospital outpatient setting or in a physician's office • delivered by qualified personnel who make sure benefit exceeds harm and who are trained in exercise therapy for PAD • under the direct supervision of a physician, physician assistant (PA), or nurse practitioner (NP)/clinical nurse This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Supervised exercise therapy (SET) (continued) specialist (CNS) trained in both basic and advanced life support techniques <i>Talk to your provider to get a prior authorization.</i>	
Transportation Essentials - Enhanced Service Eligible members can select between a gas card or a rideshare card. <i>No eligibility limits.</i> <i>\$50 limit. One selection per member per year</i>	\$0
Transportation - Supplemental This plan offers coverage for 60, one-way, routine transportation services every year. 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, fitness centers, 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 • Rideshare This benefit is continued on the next page	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Transportation - Supplemental (continued) • 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 care Urgently needed care is care given to treat: • a non-emergency that requires immediate medical care, or • an unforeseen illness, or • an injury, or • a condition that needs care right away. If you require urgently needed care, you should first try to get it from a network provider. However, you can use out-of-network providers when you can't get to a network provider because given your time, place, or circumstances, it is not possible, or it is unreasonable, to obtain services from network providers (for example, when you are outside the plan's service area and you require medically needed immediate services for an unseen condition but it is not a medical emergency). 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. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Urgently needed care (continued) Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. 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, seven days a week, 365 days a year.	
Video Doctor Visits - Supplemental 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 needed¹. - 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 This benefit is continued on the next page	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



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Covered Service	What you pay
Video Doctor Visits - Supplemental (continued) therapist² or make an appointment and talk with a psychiatrist³ 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. ¹Prescription is prescribed based on physician recommendations and state regulations (rules). ²Appointments are typically scheduled within seven days, but may vary based on therapist/psychologist availability. Video psychologists or therapists cannot prescribe medications. ³Appointments are typically scheduled within 28 days, but may vary based on psychiatrist availability. Video psychiatrists cannot prescribe controlled substances.	
 Vision care We pay for outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. For example, treatment for age-related macular degeneration. For people at high risk of glaucoma, we pay for one glaucoma screening each year. People at high risk of glaucoma include: • people with a family history of glaucoma • people with diabetes • African-Americans who are age 50 and over • Hispanic Americans who are 65 or over For people with diabetes, we pay for screening for diabetic retinopathy once per year. We pay for one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens.If you This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Vision care (continued) have two separate cataract surgeries, you must get one pair of glasses after each surgery. You cannot get two pairs of glasses after the second surgery, even if you did not get a pair of glasses after the first surgery.	
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 \$300.00 for eyeglasses or contact lenses every year. Refractions are covered as part of a routine eye exam and are not covered if billed separately. 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.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.
Vision Rehabilitation Training - Enhanced Service Members with a visual impairment receive an in-home assessment and training on managing tasks necessary for daily life. <i>No eligibility or benefit limits.</i>	\$0
 “Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • a review of your health,	\$0
This benefit continues on the next page.	



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Covered Service	What you pay
 “Welcome to Medicare” preventive visit - education and counseling about preventive services you need (including screenings and shots (or vaccines)), and - referrals for other care if you need it Note: We cover the “Welcome to Medicare” preventive visit only during the first 12 months that you have Medicare Part B. When you make your appointment, tell your doctor’s office you want to schedule your “Welcome to Medicare” preventive visit.	

Dental services – supplemental limitations and exclusions

Our plan partners with a dental vendor 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 Indiana 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 our dental vendor plan's clinical guidelines, you may call the dental vendor's Member Services or search the dental vendor's website. 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 Benefit 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

Preventive and Diagnostic Services - These services help your dentist find problems with your teeth, gums, and mouth and keep your teeth healthy and stop problems before they start. These include exams, cleanings, X-rays, and special tests.



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Exams

Code	Service	How Often It's Covered	Need Approval First?
D0120	Check-up exam	2 of (D0120–D0180) every year	No
D0140	Problem-focused exam	2 of (D0120–D0180) every year	No
D0150	New patient full exam	2 of (D0120–D0180) every year	No
D0160	Detailed evaluation	2 of (D0120–D0180) every year	No
D0170	Re-check for a specific issue	2 of (D0120–D0180) every year	No
D0171	Post-surgery follow-up	2 of (D0120–D0180) every year	No
D0180	Gum health exam	2 of (D0120–D0180) every year	No

When it is covered:

- Your dentist needs to check for oral problems, gum disease, or jaw issues.
- You are having pain or symptoms that need diagnosis.
- Images or tests are needed before treatment like fillings, braces, or surgery.

When it is not covered:

- The service is only for cosmetic reasons or not medically necessary.
- You already had the maximum number allowed and didn't get approval for more.

X-rays

Code	Service	How Often It's Covered	Need Approval First?
D0210	Full mouth X-rays	1 of (D0210, D0330, D0709) every 3 years	No
D0220	First single tooth X-ray	As needed	No



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Code	Service	How Often It's Covered	Need Approval First?
D0230	Extra tooth X-ray	As needed	No
D0240	Top-down X-ray	2 per day	No
D0250	2D side X-ray	As needed	No
D0251	Back tooth X-ray	As needed	No
D0270	1 bitewing X-ray	2 of (D0270–D0274, D0708) per year	No
D0272	2 bitewing X-rays	2 of (D0270–D0274, D0708) per year	No
D0273	3 bitewing X-rays	2 of (D0270–D0274, D0708) per year	No
D0274	4 bitewing X-rays	2 of (D0270–D0274, D0708) per year	No
D0277	Vertical bitewings	1 every 3 years	No
D0310	Salivary duct scan	As needed	No
D0330	Panoramic jaw image	1 of (D0210, D0330, D0709) every 3 years	No
D0340	Head and jaw image	As needed	No
D0364	3D scan (partial view)	As needed	No
D0365	3D scan (bottom jaw)	As needed	No
D0366	3D scan (upper jaw)	As needed	No
D0367	3D scan (both jaws)	As needed	No
D0368	3D scan for jaw joint	As needed	No
D0380	Limited cavity scan	As needed	No
D0381	Bottom jaw cavity scan	As needed	No
D0382	Upper jaw cavity scan	As needed	No
D0383	Full jaw cavity scan	As needed	No
D0384	Jaw joint cavity scan	As needed	No



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Code	Service	How Often It's Covered	Need Approval First?
D0707	Inside-mouth image	As needed	No
D0708	Bitewing image only	2 of (D0270–D0274, D0708) per year	No
D0709	Full mouth image capture only	1 of (D0210, D0330, D0709) every 3 years	No

When it is covered:

Your dentist needs to check for oral problems, gum disease, or jaw issues.

- You are having pain or symptoms that need diagnosis.
- Images or tests are needed before treatment like fillings, braces, or surgery.

When it is not covered:

- The service is only for cosmetic reasons or not medically necessary.
- You already had the maximum number allowed and didn't get approval for more.

Other Diagnostic Services

Code	Service	How Often It's Covered	Need Approval First?
D0411	HbA1c diabetes test	As needed	No
D0460	Nerve check test	As needed	No
D0486	Lab result review	As needed	No

When it is covered:

- Your dentist needs to check for oral problems, gum disease, or jaw issues.
- You are having pain or symptoms that need diagnosis.
- Images or tests are needed before treatment like fillings, braces, or surgery.

When it is not covered:

- The service is only for cosmetic reasons or not medically necessary.
- You already had the maximum number allowed and didn't get approval for more.



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Cleanings

Code	Service	How Often It's Covered	Need Approval First?
D1110	Adult teeth cleaning	2 of (D1110, D4346, D4910) every calendar year	No

When it is covered:

- These services help remove plaque and tartar to keep your teeth and gums healthy.

When it is not covered:

- You already had the allowed number of cleanings for the year or the service is just for cosmetic reasons.

Fluoride Treatments

Code	Service	How Often It's Covered	Need Approval First?
D1206	Fluoride varnish	2 of (D1206, D1208) every calendar year	No
D1208	Fluoride treatment (not varnish)	2 of (D1206, D1208) every calendar year	No

When it is covered:

- You are at risk for cavities or your dentist recommends extra protection for your teeth.

When it is not covered:

- Used more often than allowed or only for cosmetic reasons.

Other Preventive Services:**Caries Prevention (Stops or Prevents Cavities)**

Code	Service	How Often It's Covered	Need Approval First?
D1354	Stops cavities without drilling (SDF)	As needed (up to 2x per tooth)	No
D1355	Tooth treatment to prevent cavities	Once per tooth every 3 years	No



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When it is covered:

- You are at moderate or high risk of getting cavities, and the tooth does not already have a filling or crown.

When it is not covered:

- Used with fluoride on the same day, or applied to teeth with fillings, crowns, or baby teeth that are about to fall out.

Space Maintainer Removals

Code	Service	How Often It's Covered	Need Approval First?
D1556	Remove space maintainer (one side)	As needed	No
D1557	Remove space maintainer (top, both sides)	As needed	No
D1558	Remove space maintainer (bottom, both sides)	As needed	No

When it is covered:

- Your child had a space maintainer placed to hold space for adult teeth, and it now needs to be removed.

When it is not covered:

- The space maintainer was not placed correctly, or removal is done too soon without dental need.

Other Preventive-related Services

Code	Service	How Often It's Covered	Need Approval First?
D1320	Tobacco counseling	As needed	No
D1999	Other preventive treatment	If approved	Yes

When it is covered:

- Your dentist needs to provide a preventive service that isn't listed elsewhere, and it gets prior approval.



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When it is not covered:

- The service isn't clearly explained or medically necessary.

Comprehensive Services – This is more advanced dental care such as 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, and other related specialized procedures), and adjunctive general services (emergency treatment, sedation, anesthesia, night guards).

Restorative Dental Services - These services fix or rebuild damaged teeth. They include fillings, crowns, posts, and repairs.

Fillings, Inlays, and Onlays

Code	Service	How Often It's Covered	Need Approval First?
D2140	1-surface silver filling	1 per surface every 2 years	No
D2150	2-surface silver filling	1 per surface every 2 years	No
D2160	3-surface silver filling	1 per surface every 2 years	No
D2161	4+ surface silver filling	1 per surface every 2 years	No
D2330	1-surface tooth-colored front filling	1 per surface every 2 years	No
D2331	2-surface tooth-colored front filling	1 per surface every 2 years	No
D2332	3-surface tooth-colored front filling	1 per surface every 2 years	No
D2335	4+ surface front filling with corner	1 per surface every 2 years	No
D2390	Tooth-colored crown (front tooth)	1 per tooth every 2 years	No
D2391	1-surface tooth-colored back filling	1 per surface every 2 years	No



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Code	Service	How Often It's Covered	Need Approval First?
D2392	2-surface tooth-colored back filling	1 per surface every 2 years	No
D2393	3-surface tooth-colored back filling	1 per surface every 2 years	No
D2394	4+ surface tooth-colored back filling	1 per surface every 2 years	No
D2542–D2664	Inlays/onlays (metal, ceramic, resin)	1 per tooth every 5 years	No

When it is covered:

- The tooth has a cavity or is chipped.
- A filling came out or needs to be replaced.
- The tooth can be fixed with a regular or lab-made piece.

When it is not covered:

- The filling is just for looks.
- A sealant or fluoride could have been used instead.
- You had a recent filling and don't have a new reason for another.

Crowns

Code	Service	How Often It's Covered	Need Approval First?
D2710–D2794	Crowns (various materials)	1 per tooth every 5 years	Yes

When it is covered:

- The tooth is badly broken or has a big cavity.
- The tooth had a root canal and needs protection.
- The crown helps save the tooth.

When it is not covered:

- The crown is only for appearance.



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- The tooth isn't damaged enough.
- The tooth can't be fixed with a crown.

Core Build-ups and Posts

Code	Service	How Often It's Covered	Need Approval First?
D2950	Build-up under crown	1 per tooth every 5 years	Yes
D2951	Pin for holding filling	1 per tooth every 5 years	No
D2952	Post and core, lab-made	1 per tooth every 5 years	Yes
D2954	Prefab post and core	1 per tooth every 5 years	Yes
D2953, D2957	Extra posts (same tooth)	1 per tooth every 5 years	No
D2955	Remove a post	1 per tooth every 5 years	No

When it is covered:

- There's not enough tooth left to hold a crown.
- A post is needed after a root canal.

When it is not covered:

- The tooth can hold a crown without extra help.
- No root canal was done.
- The tooth is too broken to fix with a post.

Repairs

Code	Service	How Often It's Covered	Need Approval First?
D2910–D2921	Re-cement crowns or repair teeth	As needed	No



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Code	Service	How Often It's Covered	Need Approval First?
D2980–D2983	Repairs of crowns, inlays, onlays, veneers	As needed	No

When it is covered:

- A part of a crown or filling broke and needs fixing.

When it is not covered:

- The repair is just for looks.
- The tooth needs a full new crown or filling.
- Damage is too bad for just a repair.

Other Restorative-related Services

Code	Service	How Often It's Covered	Need Approval First?
D2928	Prefab ceramic crown (permanent tooth)	As needed	Yes
D2930–D2934	Prefab crowns (primary/permanent/esthetic)	As needed	No
D2940–D2949	Temporary or base restorations	As needed	No
D2971	Customize crown or denture frame	As needed	No
D2990	Special treatment for early decay	As needed	No

When it is covered:

- A special treatment stops early decay.
- It helps avoid worse problems later.

When it is not covered:

- The treatment is still being tested.



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- It's just like something you already got and don't need again.

Endodontics (Root Canal and Pulp Treatments) – Endodontic services treat the inside of the tooth, especially when the nerve or pulp becomes infected, damaged, or exposed due to deep decay or injury. These procedures can help save a tooth from being removed.

Pulp Caps and Pulpotomy (Initial Pulp Treatments)

Code	Service	How Often It's Covered	Need Approval First?
D3110	Place medication directly over exposed pulp	1 of (D3110, D3120) per tooth in a lifetime	No
D3120	Place medicine over pulp (not directly exposed)	1 of (D3110, D3120) per tooth in a lifetime	No
D3220	Remove infected pulp from top of tooth	As needed listed	No
D3221	Clean out tooth nerve for pain relief	1 per tooth in a lifetime	No
D3222	Partial pulp treatment to help root growth	As needed listed	No

When it is covered:

- Tooth has deep cavity or trauma that reaches the pulp (nerve).
- There is pain, swelling, or a dental infection.
- Treatment is needed to keep the tooth or help it finish growing.

When it is not covered:

- Tooth is badly broken and cannot be saved.
- Same tooth has already had the treatment unless medically necessary.

Pulpal Therapy for Primary (Baby) Teeth

Code	Service	How Often It's Covered	Need Approval First?
D3230	Clean and treat nerve in front baby teeth	1 of (D3230, D3240) per tooth in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D3240	Clean and treat nerve in back baby teeth	1 of (D3230, D3240) per tooth in a lifetime	No

When it is covered:

- Baby tooth has deep cavity or infection and needs to be kept until adult tooth comes in.

When it is not covered:

- Tooth is close to falling out naturally.
- Tooth cannot be restored.

Root Canal Therapy

Code	Service	How Often It's Covered	Need Approval First?
D3310	Root canal for front tooth	1 of (D3310–D3330) per tooth in a lifetime	No
D3320	Root canal for premolar tooth	1 of (D3310–D3330) per tooth in a lifetime	No
D3330	Root canal for molar tooth	1 of (D3310–D3330) per tooth in a lifetime	No

When it is covered:

- The nerve is infected but the tooth can be saved.
- Tooth is restorable after treatment.

When it is not covered:

- Tooth is broken below the gum or too damaged to fix.
- Repeated treatment is done without medical need.

Other Root Procedures

Code	Service	How Often It's Covered	Need Approval First?
D3331	Remove blockage in root canal	1 per tooth in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D3332	Stop incomplete root canal for broken/toothless tooth	1 per tooth in a lifetime	No
D3333	Repair damage inside root	1 per tooth in a lifetime	No

When it is covered:

- Problem occurs during or after root canal and can be fixed to save the tooth.

When it is not covered:

- Tooth cannot be restored or does not need the service.

Retreatment of Root Canals

Code	Service	How Often It's Covered	Need Approval First?
D3346	Repeat root canal – front tooth	1 of (D3346–D3348) per tooth in a lifetime	No
D3347	Repeat root canal – premolar	1 of (D3346–D3348) per tooth in a lifetime	No
D3348	Repeat root canal – molar	1 of (D3346–D3348) per tooth in a lifetime	No

When it is covered:

- Earlier root canal failed, and the tooth is still healthy enough to save.

When it is not covered:

- Retreatment is done within 12 months by the same dentist without new symptoms or problems.

Apexification and Recalcification (Root Growth Help)

Code	Service	How Often It's Covered	Need Approval First?
D3351	First visit to help root grow	1 per tooth in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D3352	Replace medicine during healing	1 per tooth in a lifetime	No
D3353	Final visit to finish root growth	1 per tooth in a lifetime	No

When it is covered:

- Child's tooth root hasn't finished growing due to early trauma or decay.

When it is not covered:

- Root is already fully developed.

Apicoectomy and Surgery at Tooth Root

Code	Service	How Often It's Covered	Need Approval First?
D3410	Root end surgery – front tooth	1 per tooth in a lifetime	No
D3421	Root end surgery – premolar	1 per tooth in a lifetime	No
D3425	Root end surgery – molar	1 per tooth in a lifetime	No
D3426	Root end surgery – extra root	1 per tooth in a lifetime	No

When it is covered:

- Regular root canal fails and surgery is needed to save the tooth.

When it is not covered:

- Tooth is non-restorable or cannot be saved.

Surgical Support Procedures

Code	Service	How Often It's Covered	Need Approval First?
D3428	Bone graft with root surgery – one site	1 per tooth in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D3429	Bone graft – same site, more teeth	1 per tooth in a lifetime	No
D3430	Root end filling	1 per root in a lifetime	No
D3431	Soft tissue healing material used in surgery	1 per site in a lifetime	No
D3432	Guided tissue healing used with root surgery	1 per site in a lifetime	No

When it is covered:

- Used during surgery to help bone and gums heal and keep the tooth stable.

When it is not covered:

- Surgery is not needed or tooth can't be saved.

Other Endodontic Surgery

Code	Service	How Often It's Covered	Need Approval First?
D3450	Remove one of the roots of a tooth	1 per tooth in a lifetime	No
D3920	Split tooth in half (hemisection)	1 per tooth in a lifetime	No

When it is covered:

- Only part of the tooth is infected or damaged and the healthy part can be saved.

When it is not covered:

- The whole tooth is damaged beyond repair.

Periodontics – This section includes treatments for the gums and structures that support your teeth. Services include deep cleanings, gum surgeries, and bone grafts to help manage gum disease or prepare your mouth for other dental procedures.



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Periodontal Evaluations and Maintenance

Code	Service	How Often It's Covered	Need Approval First?
D4346	Scaling for moderate/severe inflammation (full mouth)	2 of (D1110, D4346, D4910) every calendar year	No
D4355	Full mouth debridement	1 (D4355) every 2 calendar years	No
D4910	Periodontal maintenance	2 of (D1110, D4346, D4910) every calendar year	No

When it is covered:

- There is a history of gum disease (like periodontitis).
- Inflammation or plaque/tartar is present even after regular cleanings.
- It is necessary to allow for a proper gum exam or diagnosis.

When it is not covered:

- The same service has already been done within the allowed frequency.
- There is no sign of gum disease or inflammation.

Scaling and Root Planing

Code	Service	How Often It's Covered	Need Approval First?
D4341	Scaling and root planing, 4+ teeth per quadrant	1 of (D4341, D4342) per site/quad every 2 calendar years	No
D4342	Scaling and root planing, 1–3 teeth per quadrant	1 of (D4341, D4342) per site/quad every 2 calendar years	No

When it is covered:

- You have signs of gum disease, such as bleeding, deep pockets, or bone loss.

When it is not covered:

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- Regular cleanings are enough to manage your gum health.
- Done more often than the allowed time unless your dentist documents a special need.

Gum Surgery

Code	Service	How Often It's Covered	Need Approval First?
D4210	Gingivectomy, 4+ teeth per quadrant	1 of (D4210–D4212) per site/quad every 3 calendar years	No
D4211	Gingivectomy, 1–3 teeth per quadrant	1 of (D4210–D4212) per site/quad every 3 calendar years	No
D4212	Gingivectomy, for restorative purposes, per tooth	1 of (D4210–D4212) per site/quad every 3 calendar years	No
D4240	Flap procedure, 4+ teeth per quadrant	1 of (D4240–D4245) per site/quad every 3 calendar years	No
D4241	Flap procedure, 1–3 teeth per quadrant	1 of (D4240–D4245) per site/quad every 3 calendar years	No
D4245	Apically positioned flap	1 of (D4240–D4245) per site/quad every 3 calendar years	No
D4260	Osseous surgery, 4+ teeth per quadrant	1 of (D4260, D4261) per site/quad every 5 calendar years	No
D4261	Osseous surgery, 1–3 teeth per quadrant	1 of (D4260, D4261) per site/quad every 5 calendar years	No
D4268	Surgical revision procedure, per tooth	1 (D4268) per tooth every 3 calendar years	No
D4249	Crown lengthening (hard tissue)	1 (D4249) per tooth in a lifetime	No

When it is covered:



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- Gum or bone issues are preventing a proper restoration or are causing discomfort, swelling, or infection.
- Deep pockets or bone loss is present and not responding to regular treatment.

When it is not covered:

- Gums are healthy or only mildly inflamed.
- Done purely for cosmetic purposes.

Bone Grafts and Tissue Regeneration

Code	Service	How Often It's Covered	Need Approval First?
D4263	Bone graft, first site in a quadrant	1 of (D4263, D4264) per site/quad in a lifetime	No
D4264	Bone graft, each additional site in a quadrant	1 of (D4263, D4264) per site/quad in a lifetime	No
D4266	Tissue regeneration, resorbable barrier	1 of (D4266, D4267) per site/quad every 5 calendar years	No
D4267	Tissue regeneration, non-resorbable barrier	1 of (D4266, D4267) per site/quad every 5 calendar years	No
D3431	Soft tissue regeneration with periradicular surgery	1 of (D3431, D3432) per site in a lifetime	No
D3432	Guided tissue regeneration with periradicular surgery	1 of (D3431, D3432) per site in a lifetime	No

When it is covered:

- Bone or gum loss is advanced and regeneration is needed to support teeth or future dental work.

When it is not covered:

- Bone or gum structures are stable.
- Used only to improve appearance.



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Soft Tissue Grafts

Code	Service	How Often It's Covered	Need Approval First?
D4270	Pedicle soft tissue graft	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4273	Autogenous connective tissue graft, first tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4274	Mesial/distal wedge procedure, single tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4275	Non-autogenous connective tissue graft, first tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4276	Combined connective tissue and pedicle graft	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4277	Free soft tissue graft, first tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4278	Free soft tissue graft, each additional tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4283	Autogenous connective tissue graft, additional tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No
D4285	Non-autogenous connective tissue graft, additional tooth	1 of (D4270–D4285) per site/quad every 3 calendar years	No

When it is covered:

- Gum loss exposes tooth roots or causes pain/sensitivity.
- Needed to prevent further damage or tooth loss.

When it is not covered:

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- Done only to change appearance.
- Gums are healthy or issues can be managed with basic care.

Splints

Code	Service	How Often It's Covered	Need Approval First?
D4322	Intra-coronal splint	1 of (D4322, D4323) per arch every 3 calendar years	No
D4323	Extra-coronal splint	1 of (D4322, D4323) per arch every 3 calendar years	No

When it is covered:

- Teeth are loose due to gum disease or trauma and need stabilization.

When it is not covered:

- Used only for bite issues or cosmetic alignment.

Removable Prosthodontics – This section includes full and partial dentures, denture repairs, relines, tissue conditioning, and overdentures. These services help replace missing teeth and improve chewing and speaking.

Complete and Partial Dentures

Code	Service	How Often It's Covered	Need Approval First?
D5110	Complete denture, maxillary	1 per arch every 5 calendar years	No
D5120	Complete denture, mandibular	1 per arch every 5 calendar years	No
D5130	Immediate denture, maxillary	1 per arch every 5 calendar years	No
D5140	Immediate denture, mandibular	1 per arch every 5 calendar years	No



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Code	Service	How Often It's Covered	Need Approval First?
D5211–D5228	Various resin, cast, flexible base partial dentures (immediate and conventional)	1 per arch every 5 calendar years	No

When it is covered:

- You are missing multiple teeth and need help chewing or speaking.
- The dentures are replacing teeth that cannot be saved.

When it is not covered:

- The denture is being replaced too soon unless there is a documented medical need or it's broken beyond repair.

Adjustments, Repairs, and Additions

Code	Service	How Often It's Covered	Need Approval First?
D5410–D5422	Denture adjustments	1 per arch every calendar year; not payable within 6 months of initial placement by same provider	No
D5511–D5671	Repairs, additions, and tooth/clasp replacements	1 per arch every calendar year; not payable within 6 months of initial placement by same provider	No
D5725	Rebase hybrid prosthesis	1 per site every 2 calendar years	No

When it is covered:

- The denture has become loose, uncomfortable, or damaged.
- Your gums have changed shape and the denture no longer fits well.



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When it is not covered:

- You recently got a new denture and are seeking a new adjustment or repair without medical necessity.

Reline and Rebase

Code	Service	How Often It's Covered	Need Approval First?
D5710–D5721	Rebase services	1 per arch every 2 calendar years	No
D5730–D5761	Reline services	1 per arch every 2 calendar years	No

When it is covered:

- Your denture no longer fits due to gum changes and needs reshaping.

When it is not covered:

- The service is done within 6 months of getting a new denture without medical need.

Interim and Overdentures

Code	Service	How Often It's Covered	Need Approval First?
D5810–D5821	Interim complete or partial dentures	Covered as medically necessary	No
D5863–D5866	Overdentures	1 per arch every 5 calendar years	No

When it is covered:

- You're waiting for healing before a final denture is placed.
- You need a denture that attaches to implants or remaining teeth.

When it is not covered:

- The final denture is already in place unless there is documented failure of the device.



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Other Services

Code	Service	How Often It's Covered	Need Approval First?
D5850–D5851	Tissue conditioning	1 per arch every calendar year	No
D5867, D5899	Attachment repairs and unspecified prosthodontic procedures	1 per site every 5 calendar years	No
D5876	Metal substructure added to acrylic denture	Yes	Yes

When it is covered:

- Your provider confirms these services are medically necessary and submits required documentation.

When it is not covered:

- The service is experimental or not needed for chewing, speaking, or appearance.

Fixed Prosthodontics – These services include bridges, pontics, and retainer crown. These are usually done when teeth are missing and need to be replaced or supported by artificial teeth.

Pontics

Code	Service	How Often It's Covered	Need Approval First?
D6205	Pontic, indirect resin based composite	1 per tooth every 5 years	Yes
D6210	Pontic, cast high noble metal	1 per tooth every 5 years	Yes
D6211	Pontic, cast predominantly base metal	1 per tooth every 5 years	Yes
D6212	Pontic, cast noble metal	1 per tooth every 5 years	Yes
D6214	Pontic, titanium and titanium alloys	1 per tooth every 5 years	Yes



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Code	Service	How Often It's Covered	Need Approval First?
D6240	Pontic, porcelain fused to high noble metal	1 per tooth every 5 years	Yes
D6241	Pontic, porcelain fused to predominantly base metal	1 per tooth every 5 years	Yes
D6242	Pontic, porcelain fused to noble metal	1 per tooth every 5 years	Yes
D6243	Pontic, porcelain fused to titanium and titanium alloys	1 per tooth every 5 years	Yes
D6245	Pontic, porcelain/ceramic	1 per tooth every 5 years	Yes
D6250	Pontic, resin with high noble metal	1 per tooth every 5 years	Yes
D6251	Pontic, resin with predominantly base metal	1 per tooth every 5 years	Yes
D6252	Pontic, resin with noble metal	1 per tooth every 5 years	Yes

When it is covered:

- You are missing a tooth and need it replaced with a bridge.
- You cannot wear a removable denture due to medical or physical reasons.

When it is not covered:

- The current bridge still works well and doesn't need to be replaced.
- There's not enough bone or tooth support for a bridge.



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Retainers (Bridge and Prosthetic Support)

Code	Service	How Often It's Covered	Need Approval First?
D6545	Cast metal retainer for resin bonded bridge	1 per tooth every 5 years	Yes
D6548	Porcelain/ceramic retainer for resin bonded bridge	1 per tooth every 5 years	Yes
D6549	Resin retainer for resin bonded bridge	1 per tooth every 5 years	Yes
D6600–D6607	Retainer inlays (porcelain, ceramic, metal) – 2+ surfaces	1 per tooth every 5 years	Yes
D6608–D6615	Retainer onlays (porcelain, ceramic, metal) – 2+ surfaces	1 per tooth every 5 years	Yes
D6710–D6794	Retainer crowns (all materials)	1 per tooth every 5 years	Yes

When it is covered:

- You need support for a bridge that replaces a missing tooth.
- Your current retainer has failed or broken down and needs replacement.

When it is not covered:

- The retainer is only for cosmetic reasons.
- There's no clear need to replace an old one that still works properly.

Other Fixed Prosthodontic Services

Code	Service	How Often It's Covered	Need Approval First?
D6930	Re-cement or re-bond fixed bridge	As needed	No
D6980	Fixed bridge repair due to broken material	As needed	No



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When it is covered:

- The bridge is loose or broken due to regular use and needs to be fixed.

When it is not covered:

- The issue is caused by misuse or there's no medical need for the repair.

Oral and Maxillofacial Surgery – Extractions and Surgical Tooth Removal

Code	Service	How Often It's Covered	Need Approval First?
D7111	Baby tooth extraction (crown only)	As needed	No
D7140	Extraction of a tooth or root	As needed	No
D7210	Extraction requiring bone removal or tooth sectioning	As needed	No
D7220	Impacted tooth removal – soft tissue	As needed	No
D7230	Impacted tooth removal – partly in bone	As needed	No
D7240	Impacted tooth removal – fully in bone	As needed	No
D7241	Impacted tooth removal – in bone with complications	As needed	No
D7250	Removal of leftover tooth roots using cutting tools	As needed	No
D7251	Crown-only removal (coronectomy)	As needed	Yes

When it is covered:

- The tooth is broken, decayed, or causes pain or infection.
- The tooth is impacted and causing issues.



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- There's a risk of damage to other teeth or tissue.

When it is not covered:

- The removal is only for looks.
- The tooth is healthy and can be fixed.

Surgical Repairs, Sinus, and Bone Procedures

Code	Service	How Often It's Covered	Need Approval First?
D7260	Close a hole between mouth and sinus	1 per site in a lifetime	No
D7261	Close a sinus opening after surgery	1 per site in a lifetime	No
D7270	Put a tooth back in place after injury	1 per tooth in a lifetime	No
D7280	Expose a tooth that hasn't come in yet	1 per tooth in a lifetime	No
D7282	Move an out-of-place tooth	As needed	No
D7295	Take bone from another area to use in the mouth	As needed	No
D7340	Stretch the gums for denture fitting (2-step)	1 per site/quad in a lifetime	No
D7350	Stretch the gums for denture fitting	1 per site/quad in a lifetime	No
D7953	Add bone after extraction to preserve ridge	1 per site in a lifetime	No
D7970	Remove overgrown gum tissue	1 per arch every 5 calendar years	No
D7971	Remove gum flap over tooth	1 per tooth in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D7972	Reduce extra tissue behind molars	1 per quad in a lifetime	No
D7961	Remove frenum (lip area)	1 per arch every 5 calendar years	No
D7962	Remove frenum (tongue area)	1 every 5 calendar years	No
D7963	Fix abnormal frenum attachment	1 every 5 calendar years	No

When it is covered:

- Needed to support dentures or implants.
- Fixes damage or defects in the bone or sinus.
- Helps teeth grow in or stay healthy.

When it is not covered:

- Done only for looks.
- A simpler treatment would work.

Alveoloplasty (Smoothing Bone)

Code	Service	How Often It's Covered	Need Approval First?
D7310	Smooth bone with 4 or more teeth removed in a section	1 per site/quad in a lifetime	No
D7311	Smooth bone with 1–3 teeth removed in a section	1 per site/quad in a lifetime	No
D7320	Smooth bone without extractions, 4 or more teeth in a section	1 per site/quad in a lifetime	No



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Code	Service	How Often It's Covered	Need Approval First?
D7321	Smooth bone without extractions, 1–3 teeth in a section	1 per site/quad in a lifetime	No

When it is covered:

- Bone is sharp or uneven and makes it hard to fit dentures.
- Helps reduce pain or discomfort from chewing.

When it is not covered:

- Only done for appearance.
- No dentures or medical need involved.

Biopsy and Pathology

Code	Service	How Often It's Covered	Need Approval First?
D7285	Small sample of hard tissue (like bone) for testing	1 per site every 2 calendar years	No
D7286	Small sample of soft tissue for testing	1 per site every 2 calendar years	No
D7288	Brush-style tissue sample for lab testing	1 per site every 2 calendar years	No

When it is covered:

- There's a lump, bump, or abnormal area needing diagnosis.
- Testing is needed to rule out cancer or other health issues.

When it is not covered:

- Area has already been diagnosed and no changes are seen.
- No signs or symptoms that concern the dentist.



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Lesion and Tumor Removal

Code	Service	How Often It's Covered	Need Approval First?
D7410	Remove small benign growth	As needed	No
D7411	Remove large benign growth	As needed	No
D7412	Remove complicated benign growth	As needed	No
D7413	Remove small cancerous growth	As needed	No
D7414	Remove large cancerous growth	As needed	No
D7415	Remove complicated cancerous growth	As needed	No
D7450	Remove small jaw cyst or tumor	As needed	No
D7451	Remove large jaw cyst or tumor	As needed	No
D7460	Remove small non-jaw cyst or tumor	As needed	No
D7461	Remove large non-jaw cyst or tumor	As needed	No
D7465	Remove lesion with heat or chemicals	As needed	No

When it is covered:

- The growth or cyst causes pain, swelling, or health risks.
- A biopsy or imaging supports the need for removal.

When it is not covered:

- It's cosmetic.
- No signs or symptoms are present.



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Foreign Body and Abscess Treatment

Code	Service	How Often It's Covered	Need Approval First?
D7510	Drain abscess in soft mouth tissue	As needed	No
D7511	Drain abscess in soft tissue, complex case	As needed	No
D7520	Drain abscess in outer face tissue	As needed	No
D7521	Drain abscess in outer tissue, complex case	As needed	No
D7530	Remove item stuck in mouth lining	As needed	No
D7540	Remove item stuck in bone or muscle	As needed	No

When it is covered:

- Infection, swelling, or blockage is present.
- A dentist determines immediate care is needed.

When it is not covered:

- No symptoms are present.
- Item does not cause discomfort or risk.

Fractures, TMJ, and Sutures

Code	Service	How Often It's Covered	Need Approval First?
D7610–D7780	Treatment of broken jaw, facial bones, or splints	As needed	No
D7810	Surgery for dislocated jaw joint (TMJ)	As needed	No
D7820	Manual movement of TMJ (non-surgical)	As needed	No



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Code	Service	How Often It's Covered	Need Approval First?
D7910	Stitch recent wound (up to 5 cm)	As needed	No
D7911	Stitch wound (up to 5 cm)	As needed	No
D7912	Stitch complex wound (over 5 cm)	As needed	No

When it is covered:

- There is trauma, injury, or dysfunction of the jaw or face.
- Treatment is needed to restore function or close wounds.

When it is not covered:

- The procedure is cosmetic.
- No clinical signs of injury or medical need.

Other Oral Surgery Procedures

Code	Service	How Often It's Covered	Need Approval First?
D7560	Open sinus surgery (sinusotomy)	As needed	No
D7997	Remove dental appliance placed by another dentist	1 every 5 calendar years	No
D7979	Non-surgical removal of salivary stone	As needed	No
D7980	Surgical removal of salivary stone	As needed	No
D7982	Salivary duct surgery (sialodochoplasty)	As needed	No
D7983	Close salivary gland fistula	As needed	No



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Code	Service	How Often It's Covered	Need Approval First?
D7999	Other oral surgery (with documentation)	As needed	Yes

When it is covered:

- Required for medical or functional reasons, as determined by a dentist.
- Surgery addresses infection, swelling, or serious oral health issues.

When it is not covered:

- Procedure is cosmetic or not medically necessary.
- Lacks proper documentation if required.

Adjunctive General Services – Emergency and Palliative Care

Code	Service	How Often It's Covered	Need Approval First?
D9110	Emergency minor treatment to relieve pain	2 every calendar year	No
D9920	Behavior Management	As needed	No
D9930	Treat unusual post-surgical complications	As needed	No

When it is covered:

- You have pain, infection, or urgent discomfort.
- Needed to stabilize your condition before further treatment.

When it is not covered:

- Used in place of standard care.
- Repeated often without a new issue.



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Bridge Modification

Code	Service	How Often It's Covered	Need Approval First?
D9120	Cutting a bridge to remove part	As needed	No

When it is covered:

- A portion of the bridge needs to be removed due to damage or to treat a nearby tooth.
- It's part of a medically necessary treatment.

When it is not covered:

- The service is not related to a covered dental problem.
- Removal is for cosmetic purposes only.

Sedation and Anesthesia

Code	Service	How Often It's Covered	Need Approval First?
D9222	Deep sedation/general anesthesia, first 15 minutes	As needed	No
D9223	Deep sedation/general anesthesia, each additional 15 minutes	As needed	No
D9230	Laughing gas (nitrous oxide)	As needed	No
D9239	IV sedation, first 15 minutes	As needed	No
D9243	IV sedation, each additional 15 minutes	As needed	No
D9248	Non-IV sedation (includes oral medications)	As needed	No

When it is covered:

- Needed to complete covered dental treatment safely.



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- Anxiety, behavior, or medical condition makes sedation necessary.

When it is not covered:

- Chosen only for comfort with no medical need.
- Used with services not covered by your plan.

Desensitizing and Drug Therapy

Code	Service	How Often It's Covered	Need Approval First?
D9610	One-time medicine given by injection	As needed	No
D9910	Desensitizing medicament for tooth pain	1 every calendar year	No
D9911	Desensitizing resin for root surfaces, per tooth	1 per tooth every calendar year	No

When it is covered:

- Helps manage tooth sensitivity or pain.
- Part of a treatment plan to restore or protect teeth.

When it is not covered:

- Used alone without a dental condition or treatment need.

Occlusal Guards and Adjustments

Code	Service	How Often It's Covered	Need Approval First?
D9942	Fix or reline a night guard	1 every calendar year	No
D9944	Hard night guard, full arch	1 of (D9944–D9946) every 3 years	No
D9945	Soft night guard, full arch	1 of (D9944–D9946) every 3 years	No
D9946	Hard night guard, partial arch	1 of (D9944–D9946) every 3 years	No



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Code	Service	How Often It's Covered	Need Approval First?
D9947	Sleep apnea appliance	As needed	Yes
D9948	Adjust sleep apnea appliance	As needed	No
D9949	Repair sleep apnea appliance	As needed	No
D9950	Analysis of bite using models	As needed	No
D9951	Minor adjustment to bite	1 of (D9951, D9952) every 2 years	No
D9952	Full bite adjustment	1 of (D9951, D9952) every 2 years	No

When it is covered:

- You have issues like teeth grinding, jaw pain, or bite problems.
- Part of treatment for covered dental conditions.

When it is not covered:

- Used just for comfort or cosmetic reasons.
- No signs of damage or medical need.

Teledentistry and Other Visits

Code	Service	How Often It's Covered	Need Approval First?
D9310	Dental consultation (not from your main dentist)	As needed	No
D9410	Dentist visit to home or care facility	As needed	No
D9995	Live video dental visit	2 of (D9995, D9996) every calendar year	No
D9996	Recorded dental visit sent to dentist	2 of (D9995, D9996) every calendar year	No



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When it is covered:

- You can't travel easily or need a second opinion.
- The service supports treatment or diagnosis.

When it is not covered:

- Not related to a dental concern.
- Used for convenience with no dental need.

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 the dental vendor's criteria, will be denied.
- Any procedure not specifically listed as a covered benefit in the Dental services - Supplemental section of the Chapter 4 Medical Benefits Chart 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.

The dental vendor'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 information 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.



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Additional services may be covered in accordance with your Medicaid benefits and guidelines. Certain dental services are available through the Medicaid Dental Program.

Please call your dental benefits manager for more information.

E. Benefits covered outside of our plan

The Indiana PathWays for Aging program excludes some benefits from coverage under our plan. These benefits are available under traditional Medicaid or other waiver programs and are therefore excluded from our plan as described below. A member who is, or will be, receiving excluded services must be disenrolled from our plan to be eligible for the services. Excluded services are defined by the State as services that aren't covered under Indiana Medicaid.

We don't cover the following services, but they're available through traditional Medicaid or other waiver programs.

- Traditional Medicaid Psychiatric Treatment in a State Hospital
- Intermediate Care Facilities for Individuals with Intellectual Disabilities
- Traumatic Brain Injury Waiver
- Community Integration and Habilitation Waiver
- Family Supports Waiver

F. Benefits not covered by our plan, Medicare, or Indiana PathWays for Aging

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Indiana PathWays for Aging don't pay for them either.

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

We don't pay for excluded medical benefits listed in this section (or anywhere else in this *Member Handbook*) except under specific conditions listed. Even if you get the services at an emergency facility, the plan won't pay for the services. If you think that our plan should pay for a service that isn't covered, you can request an appeal. For information about appeals, refer to **Chapter 9** of this *Member Handbook*.

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



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- services considered not “reasonable and medically necessary,” according to Medicare and Indiana PathWays for Aging standard, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of this *Member Handbook* for more information on clinical research studies. Experimental treatment and items are those that aren’t generally accepted by the medical community.
- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- private duty nurses
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- full-time nursing care in your home
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it’s needed because of an accidental injury or to improve a part of the body that isn’t shaped right. However, we pay for reconstruction of a breast after a mastectomy and for treating the other breast to match it
- chiropractic care, other than manual manipulation of the spine consistent with coverage guidelines
- routine foot care, except as described in Podiatry services in the Benefits Chart in **Section D**
- orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease
- supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease
- radial keratotomy, LASIK surgery
- reversal of sterilization procedures and non-prescription contraceptive supplies
- naturopath services (the use of natural or alternative treatments)
- services provided to veterans in Veterans Affairs (VA) facilities. However, when a veteran gets emergency services at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse the veteran for the difference. You are still responsible for your cost-sharing amounts.



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Chapter 5: Getting your outpatient drugs

Introduction

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

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

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

Rules for our plan's outpatient drug coverage

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

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

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

You generally must use a network pharmacy to fill your prescription (Refer to **Section A1** for more information). Or you can fill your prescription through the plan's mail-order service.

Your prescribed drug must be on our plan's *List of Covered Drugs*. We call it the *Drug List* for short. (Refer to **Section B** of this chapter)

- If it isn't on the *Drug List*, we may be able to cover it by giving you an exception.
- Refer to **Chapter 9** to learn about asking for an exception.

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

For Indiana PathWays for Aging drugs that may not be designated by CMS as less than effective or identical, related, or similar to less than effective drug; and not specifically excluded from coverage by Indiana Medicaid

Your drug may require approval from our plan based on certain criteria before we'll cover it. (Refer to **Section C** in this chapter.)

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A. Getting your prescriptions filled

A1. Filling your prescription at a network pharmacy

In most cases, we pay for prescriptions only when filled at any of our network pharmacies. A network pharmacy is a drug store that agrees to fill prescriptions for our plan members. You may use any of our network pharmacies. (Refer to **Section A8** for information about when we cover prescriptions filled at out-of-network pharmacies.)

To find a network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website or contact Member Services.

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

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

If you don't have your Member ID Card with you when you fill your prescription, ask the pharmacy to call us to get the necessary information, or you can ask the pharmacy to look up your 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. Then you can ask us to pay you back. **If you can't pay for the drug, contact Member Services right away.** We'll do everything we can to help.

- To ask us to pay you back, refer to **Chapter 7** of this *Member Handbook*.
- If you need help getting a prescription filled, contact Member Services.

A3. What to do if you change your network pharmacy

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

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

A4. What to do if your pharmacy leaves the network

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

To find a new network pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A5. Using a specialized pharmacy

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

- Pharmacies that supply drugs for home infusion therapy.
- Our plan will cover home infusion therapy if:
 - Your prescription drug is on our plan's formulary, or a formulary exception has been granted for your prescription drug.
 - Your prescription drug is not otherwise covered under our plan's medical benefit.
 - Our plan has approved your prescription for home infusion therapy.
 - Your prescription is written by an authorized prescriber.
 - If you need help finding a home infusion pharmacy provider in your area, please call Member Services 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 Member Services, or request one at our website.
- Pharmacies that supply drugs for residents of a long-term care facility, such as a nursing facility.
 - Usually, long-term care facilities have their own pharmacies. If you're a resident of a long-term care facility, we make sure you can get the drugs you need at the facility's pharmacy.
 - If your long-term care facility's pharmacy is not in our network or you have difficulty getting your drugs in a long-term care facility, contact Member Services.
- Pharmacies that serve the Indian Health Service/Tribal/Urban Indian Health Program. Except in emergencies, only Native Americans or Alaska Natives may use these pharmacies.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.) To find a specialized pharmacy, refer to the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.

A6. Using mail-order services to get your drugs

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, drugs available through mail-order are drugs that you take on a regular basis for a chronic or long-term medical condition.

Drugs available through our plan's mail-order service are marked as mail-order drugs in our Drug List.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Our plan's mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90- or 100-day supply. A 90- or 100-day supply has the same copay as a one-month supply.

Filling prescriptions by mail

To get order forms and information about filling your prescriptions by mail, call our mail-order Member Services at 1-833-203-1735 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, 7 days a week.

Usually, a mail-order prescription arrives within 14 days. Make sure you have at least one 30-day supply of medication on hand. If you do not have enough, ask your doctor to give you a second prescription for a 30-day supply, and fill it at a retail network pharmacy while you wait for your mail-order supply to arrive. If your mail-order shipment is delayed, please call the mail-order pharmacy at the phone number provided in the *Provider and Pharmacy Directory*.

Mail-order processes

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

1. New prescriptions the pharmacy gets from you

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

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, please contact us by calling the Member Services phone number on your membership card.

If you have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. This will give you an opportunity to make sure that the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allow you to cancel or delay the order before it is shipped.

It's important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

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

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



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- You used mail-order services with our plan in the past, **or**
- You sign up for automatic delivery of all new prescriptions you get directly from health care providers. You may ask for automatic delivery of all new prescriptions now or at any time by providing consent on your first new home delivery prescription, sent in by your physician.

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

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

- This gives you an opportunity to make sure the pharmacy is delivering the correct drug (including strength, amount, and form) and, if necessary, allows you to cancel or delay the order before it's shipped.
- Respond each time the pharmacy contacts you, to let them know what to do with the new prescription and to prevent any delays in shipping.

To opt out of automatic deliveries of new prescriptions you get directly from your health care provider's office, contact us by calling the Member Services phone number on your membership card.

3. Refills on mail-order prescriptions

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

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

To opt out of our auto refill program that automatically prepares mail-order refills, contact us by calling Member Services.

Let the pharmacy know the best ways to contact you so they can reach you to confirm your order before shipping. Call our mail-order Member Services at 1-833-203-1735. TTY users should call 711. Hours are 24 hours a day, 7 days a week.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A7. Getting a long-term supply of drugs

You can get a long-term supply of maintenance drugs on our plan's *Drug List*. Maintenance drugs are drugs you take on a regular basis, for a chronic or long-term medical condition.

Some network pharmacies allow you to get a long-term supply of maintenance drugs. A 90 or 100 day supply has the same copay as a one-month supply. The Provider and Pharmacy Directory tells you which pharmacies can give you a long-term supply of maintenance drugs. You can call Member Services for more information.

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

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

Generally, we pay for drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. In these cases, check with Member Services first to find out if there's a network pharmacy nearby.

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

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

In these situations, please check first with Member Services to see if there is a network pharmacy nearby.

A9. Paying you back for a prescription

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



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you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

To learn more about this, refer to **Chapter 7** of this *Member Handbook*.

B. Our plan's *Drug List*

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

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

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

B1. Drugs on our *Drug List*

Our Drug List includes drugs covered under Medicare Part D, as well as certain injections and infusions, prescription and over-the-counter (OTC) drugs, pharmacy supplements, and other specified products covered under Indiana PathWays for Aging.

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

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

Generic drugs have the same active ingredients as brand name drugs. Biological products have alternatives called biosimilars. Generally, generic drugs and biosimilars work just as well as brand name or original biological products 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.

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

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

B2. How to find a drug on our *Drug List*

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- Visit our plan's website at www.anthem.com. The Drug List on our website is always the most current one.
- Call Member Services to find out if a drug is on our Drug List or to ask for a copy of the list.
- Use our "Real Time Benefit Tool" at www.anthem.com to search for drugs on the *Drug List* to get an estimate of what you'll pay and if there are alternative drugs on the *Drug List* that could treat the same condition. You can also call Member Services.

B3. Drugs not on our *Drug List*

We don't cover all drugs.

- Some drugs aren't on our *Drug List* because the law doesn't allow us to cover those drugs.
- In other cases, we decided not to include a drug on our *Drug List*.
- In some cases, you may be able to get a drug that isn't on our *Drug List*. For more information refer to **Chapter 9**.

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

Here are three general rules for excluded drugs:

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

Also, by law, Medicare or Indiana PathWays for Aging can't cover the types of drugs listed below.

- Drugs used to promote fertility
- Drugs used for cosmetic purposes or to promote hair growth
- Drugs used for the treatment of sexual or erectile dysfunction



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

B4. Drug List tiers

Every drug on our *Drug List* is in one of five tiers. A tier is a group of drugs of generally the same type (for example, brand name, generic, or OTC drugs).

- **Tier 1 - Preferred Generic:** Common medication for ongoing conditions.
- **Tier 2 - Generic:** Generic drugs and may include some brand name drugs.
- **Tier 3 - Preferred Brand:** Commonly used brand name drugs and may also include generic drugs.
- **Tier 4 - Non-Preferred Drug:** Brand name and generic drugs.
- **Tier 5 - Specialty Tier:** Drugs for complex or serious conditions.

To find out which tier your drug is in, look for the drug on our *Drug List*.

Chapter 6 of this *Member Handbook* tells the amount you pay for drugs in each tier.

C. Limits on some drugs

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

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 provider, and different restrictions may apply to the different versions of the drugs (for example, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid.)

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

To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Generally, a generic drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. In most cases, if there's a generic or interchangeable biosimilar version of a brand name drug or original biological product available, our network pharmacies give, respectively, the generic or interchangeable biosimilar version.

- We usually don't pay for the brand name drug or original biological product when there's an available generic version.
- However, if your provider told us the medical reason that the generic drug won't work for you **or** wrote "No substitutions" on your prescription for a brand name drug **or** told us the medical reason that the generic drug or other covered drugs that treat the same condition won't work for you, then we cover the brand name drug.

2. Getting plan approval in advance

For some drugs, you or your prescriber must get approval from our plan before you fill your prescription. 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 approval, we may not cover the drug. Call Member Services at the number at the bottom of the page or on our website at www.anthem.com for more information about prior authorization.

3. Trying a different drug first

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

If Drug A **doesn't** work for you, then we cover Drug B. This is called step therapy. Call Member Services at the number at the bottom of the page or on our website at www.anthem.com for more information about step therapy.

4. Quantity limits

For some drugs, we limit the amount of the drug you can have. This is called a quantity limit. For example, if it's normally considered safe to take only one pill per day for a certain drug, we might limit how much of a drug you can get each time you fill your prescription.

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

D. Reasons your drug might not be covered

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



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

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

D1. Getting a temporary supply

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

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

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



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- o Long-term care pharmacies may provide your prescription drug in small amounts at a time to prevent waste.
- You have been in our plan for more than 90 days, live in a long-term care facility, and need a supply right away.
 - o We cover one 34-day supply, or less if your prescription is written for fewer days. This is in addition to the temporary supply above.

D2. Asking for a temporary supply

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

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

- Change to another drug.

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

OR

- Ask for an exception.

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

D3. Asking for an exception

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

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

To learn more about asking for an exception, refer to **Chapter 9** of this *Member Handbook*.

If you need help asking for an exception, contact Member Services.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

E. Coverage changes for your drugs

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

- Decide to require or not require prior authorization for a drug (permission from us before you can get a drug).
- Add or change the amount of a drug you can get (quantity limits).
- Add or change step therapy restrictions on a drug (you must try one drug before we cover another drug).
- 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*. For more information on these drug rules, refer to **Section C**

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

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

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

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

- Check our current *Drug List* online at www.anthem.com **or**
- Call Member Services at the number at the bottom of the page to check our current *Drug List*.

Changes we may make to the *Drug List* that affect you during the current plan year

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

- A new generic drug becomes available. Sometimes, a new generic drug or biosimilar comes on the market that works as well as a brand name drug or original biological product on the *Drug List* now. When that happens, we may remove the brand name drug and add the new generic drug, but your cost for the new drug will stay the same.

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o You or your provider can ask for an “exception” from these changes. We’ll send you a notice with the steps you can take to ask for an exception. Please refer to **Chapter 9** of this *Member Handbook* for more information on exceptions.

Removing unsafe drugs and other drugs that are taken off the market. Sometimes a drug may be found unsafe or taken off the market for another reason. If this happens, we may immediately take it off our *Drug List*. If you're taking the drug, we'll send you a notice after we make the change. Your prescriber will also know about this change and can work with you to find another drug for your condition.

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

- The FDA provides new guidance or there are new clinical guidelines about a drug.

When these changes happen, we:

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

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

- If there's a similar drug on our *Drug List* you can take instead **or**
- If you should ask for an exception from these changes to continue covering the drug or the version of the drug you've been taking. To learn more about asking for exceptions, refer to **Chapter 9** of this *Member Handbook*.

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

We may make changes to drugs you take that aren't described above and don't affect you now. For such changes, if you're taking a drug we covered at the **beginning** of the year, we generally don't remove or change coverage of that drug **during the rest of the year**.

For example, if we remove a drug you're taking or limit its use, then the change doesn't affect your use of the drug for the rest of the year.

If any of these changes happen for a drug you're taking (except for the changes noted in the section above), the change won't affect your use until January 1 of the next year.

We won't tell you about these types of changes directly during the current 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 that will impact you during the next plan year.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

F. Drug coverage in special cases

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

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

F2. In a long-term care facility

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

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

F3. In a Medicare-certified hospice program

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

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

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

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

G. Programs on drug safety and managing drugs

G1. Programs to help you use drugs safely

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

- may not be needed because you take another similar drug that does the same thing



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- may not be safe for your age or gender
- could harm you if you take them at the same time
- have ingredients that you are or may be allergic to
- may be an error in the amount (dosage)
- have unsafe amounts of opioid pain medications

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

G2. Programs to help you manage your drugs

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

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

Then, they will give you:

- A written summary of this discussion. The summary has a medication action plan that recommends what you can do for the best use of your medications.
- A personal medication list that includes all medications you take, how much you take, and when and why you take them.
- Information about safe disposal of prescription medications that are controlled substances.

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

If you have questions about these programs, contact Member Services.

G3. 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 prescriber to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescriber, 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 include:

- Requiring you to get all 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'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific provider or pharmacy.

You'll have a chance to tell us which prescribers or pharmacies you prefer to use and any 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 that confirms the limitations.

If you think we made a mistake, you disagree with our decision or the limitation, you and your prescriber can make an appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your appeal related to limitations that apply to your access to medications, we'll automatically send your case to an Independent Review Organization (IRO). (To learn more about appeals and the IRO, refer to **Chapter 9** of this *Member Handbook*.)

The DMP may not apply to you if you:

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 6: What you pay for your Medicare and Indiana PathWays for Aging drugs

Introduction

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

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

Because you’re eligible for Indiana PathWays for Aging, you get Extra Help from Medicare to help pay for your Medicare Part D drugs.

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

Other key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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

- *Our List of Covered Drugs.*
 - We call this the *Drug List*. It tells you:
 - which drugs we pay for
 - which of the five tiers each drug is in
 - If there are any limits on the drugs
 - If you need a copy of our *Drug List*, call Member Services. You can also find the most current copy of our *Drug List* on our website at www.anthem.com.
- **Chapter 5** of this *Member Handbook*.
 - It tells how to get your outpatient drugs through our plan.
 - It includes rules you need to follow. It also tells which types of drugs our plan doesn’t cover.
 - When you use the plan’s “Real Time Benefit Tool” to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is an estimate of the out-of-pocket costs you’re expected to pay. You can call Member Services for more information.
- *Our Provider and Pharmacy Directory.*



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. The Explanation of Benefits (EOB)

Our plan keeps track of your drug costs and the payments you make when you get prescriptions at the pharmacy. We track two types of costs:

- Your **out-of-pocket costs**. This is the amount of money you, or others on your behalf, pay for your prescriptions. This includes what you paid when you got a covered Part D drug, 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, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- Your **total drug costs**. This is the total of all payments made for your covered Part D drugs. It includes what our plan paid, and what other programs or organizations paid for your covered Part D drugs.

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

- **Information for the month**. The summary tells what drugs you got for the previous month. It shows the total drug costs, what we paid, and what you and others paid for you.
- **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 is the total price of the drug and changes in the drug price since the first fill for each prescription claim of the same quantity.
- **Lower cost alternatives**. When applicable, information about other available drugs with lower cost-sharing for each prescription.

We offer coverage of drugs not covered under Medicare.

- Payments made for these drugs don't count towards your total out-of-pocket costs.
- To find out which drugs our plan covers, refer to our *Drug List*. In addition to the drugs covered under Medicare, some prescription and over-the-counter drugs are covered under Indiana PathWays for Aging. These drugs are included in the *Drug List*.

B. How to keep track of your drug costs

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

1. Use your Member ID Card.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

2. Make sure we have the information we need.

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

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

- When you buy a covered drug at a network pharmacy at a special price or use a discount card that isn't part of our plan's benefit.
- When you pay a copay for drugs that you get under a drug maker's patient assistance program.
- When you buy covered drugs at an out-of-network pharmacy.
- When you pay the full price for a covered drug under special circumstances.

For more information about asking us to pay you back for a drug, refer to **Chapter 7** of this *Member Handbook*.

3. Send us information about 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 an AIDS drug assistance program (ADAP), the Indian Health Service, and most charities count toward your out-of-pocket costs.

4. Check the EOBs we send you.

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

- **Do you recognize the name of each pharmacy?** Check the dates. Did you get drugs that day?
- **Did you get the drugs listed?** Do they match those listed on your receipts? Do the drugs match what your doctor prescribed?

B1. What if you find mistakes on this summary?

If something is confusing or doesn't seem right on this EOB, please call us at Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member Services.

B2. What about possible fraud?

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- Call us at Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- Call Department of Family Resources at 800-403-0864 M-F from 8 a.m.- 4:30 p.m. Select option "5" when prompted, then enter your zip code.
- FAX: 317-234-2244
- Email: ReportFraud@fssa.IN.gov
- Fraud Reporting Mailing Address: FSSA Compliance Division, Room E-414 402 W. Washington St. Indianapolis, IN 46204

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

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

With our plan, you pay nothing for covered drugs if you follow our rules. If you lose your Medicaid eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

C1. Getting a long-term supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90- or 100-day supply. There's no cost to you for a long-term supply.

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

D. 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 Medicare Part B. Other vaccines are considered Medicare Part D drugs. You can find these vaccines listed in our *Drug List*. Our plan covers most adult Medicare Part D vaccines at no cost to you. Refer to our plan's *Drug List* or contact Member Services for coverage about specific vaccines.

There are two parts to our coverage of Medicare Part D vaccines:

1. The first part is for the cost of the vaccine itself.
2. The second part is for the cost of giving you the vaccine. For example, sometimes you may get the vaccine as a shot given to you by your doctor.



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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

Introduction

This chapter tells you how and when to send us a bill to ask for payment. It also tells you how to make an appeal if you don't agree with a coverage decision. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. Asking us to pay for your services or drugs

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

We don't allow Anthem I PathWays Dual Care Advantage (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

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

- If we cover the services or drugs, we'll pay the provider directly.
- If we cover the services or drugs and you already paid the bill, it's your right to be paid back.
 - If you paid for services covered by Medicare, we'll pay you back.
 - If you paid for services covered by Indiana PathWays for Aging we can't pay you back, but the provider will. Member Services can help you contact the provider's office. Refer to the bottom of the page for the Member Services phone number.
- If we don't cover the services or drugs, we'll tell you.

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

Examples of times when you may need to ask us to pay you back or to pay a bill you got include:

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

Ask the provider to bill us.

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

2. When a network provider sends you a bill

Network providers must always bill us. It's important to show your Member ID Card when you get any services or prescriptions. But sometimes they make mistakes and ask you to pay for your



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

services or more than your share of the costs. **Call Member Services** at the number at the bottom of this page **if you get any bills**.

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

3. If you're retroactively enrolled in our plan

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

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

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

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

- In only a few cases, we'll cover prescriptions filled at out-of-network pharmacies. Send us a copy of your receipt when you ask us to pay you back.
- Refer to **Chapter 5** of this *Member Handbook* to learn more about out-of-network pharmacies.
- 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 Medicare Part D prescription cost because you don't have your Member ID Card with you

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

- If the pharmacy can't get the information right away, you may have to pay the full prescription cost yourself or return to the pharmacy with your Member ID Card.
- Send us a copy of your receipt when you ask us to pay you back.
- 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 Medicare Part D prescription cost for a drug that's not covered



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

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

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

B. Sending us a request for payment

Send us your bill and proof of any payment you made for Medicare services. Proof of payment can be a copy of the check you wrote or a receipt from the provider. **It's a good idea to make a copy of your bill and receipts for your records.** You can ask your care coordinator for help. You must send your information to us within one year of the date you got the service, item, or drug.

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

- You aren't required to use the form, but it helps us process the information faster.
- You can get the form on our website www.anthem.com, or you can call Member Services and ask for the form.

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

C. Coverage decisions

When we get your request for payment, we make a coverage decision. This means that we decide if our plan covers your service, item, or drug. We also decide the amount of money, if any, you must pay.

- We will let you know if we need more information from you.
- If we decide that our plan covers the service, item, or drug and you followed all the rules for getting it, we will pay for it. If you already paid for the service or drug, we will mail you a check for what you paid. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you obtained a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we will pay the provider directly.

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

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

D. Appeals

If you think we made a mistake in turning down your request for payment, you can ask us to change our decision. This is called “making an appeal.” You can also make an appeal if you don't agree with the amount we pay.

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 8: Your rights and responsibilities

Introduction

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

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

We must ensure **all** services, both clinical and non-clinical, are provided to you in a culturally competent and accessible manner including for those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. We must also tell you about our plan's benefits and your rights in a way that you can understand. We must tell you about your rights each year that you're in our plan.

- To get information in a way that you can understand, call Member Services. Our plan has free interpreter services available to answer questions in different languages.
- Our plan can also give you materials in languages other than English including Arabic, Burmese, Chinese, Khmer, Korean, Spanish and Vietnamese and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services at 1-833-412-4405 (TTY: 711) or write to Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187, Atlanta, GA 30348-5187.
 - o When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year.
 - o You can also call us to change or cancel a standing order.
 - o You can also find your documents online at www.anthem.com.

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

- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Indiana Family and Social Services Administration (FSSA) ADA Director at 1-317-653-5603, or email ADA@fssa.in.gov.
- U.S. Department of Health & Human Services Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697. To file a complaint or learn more about your rights visit: www.hhs.gov/ocr/complaints/index.html.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. حقك في الحصول على الخدمات والمعلومات بطريقة تلبي احتياجاتك

يجب أن نضمن تقديم جميع الخدمات السريرية وغير السريرية لك بطريقة مختصة ثقافياً، مع إمكانية الوصول إليها من قبل الأشخاص الذين لديهم كفاءة محدودة في اللغة الإنجليزية أو مهارات قراءة محدودة أو ضعف السمع أو أولئك الذين لديهم خلفيات ثقافية وعرقية متنوعة. يجب أن نخبرك أيضاً عن مزايا خطتنا وحقوقك بطريقة يمكنك فهمها. ويجب أن نخبرك عن حقوقك سنوياً طالما أنك مسجل في خطتنا.

- للحصول على المعلومات بالطريقة التي يمكنك فهمها، اتصل بقسم خدمات الأعضاء. لدينا في خطتنا خدمات الترجمة الفورية التي يمكنك الاستعانة بها للحصول على إجابة عن الأسئلة بلغات مختلفة.

- يمكن لخطتنا توفير المواد لك بلغات أخرى غير اللغة الإنجليزية، بما يشمل العربية والبورمية والصينية والخميرية والكورية والأسبانية والفيتنامية، وبتنسيقات مثل الطباعة بأحرف كبيرة أو طريقة برايل أو مسجلة صوتياً. للحصول على المواد بأحد هذه التنسيقات البديلة، يرجى الاتصال بخدمات الأعضاء على (TTY: 711) 1-833-412-4405 أو الكتابة إلى
Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187,
Atlanta, GA 30348-5187

- عند الاتصال، أخبرنا إذا كنت تريد أن يكون ذلك طلباً ثابتاً. ويعني ذلك أننا سنرسل نفس المستندات بالتنسيق المطلوب واللغة المطلوبة من جانبك كل عام.

- ويمكنك أيضاً الاتصال بنا لتغيير أو إلغاء طلب ثابت.

- يمكنك أيضاً العثور على مستنداتك عبر الإنترنت على الموقع الإلكتروني www.anthem.com.

إذا واجهت مشكلة في الحصول على معلومات من خطتنا بسبب مشكلات لغوية أو إعاقة وتريد تقديم شكوى، فاتصل على:

- Medicare على الرقم (1-800-633-4227) 1-800-MEDICARE. ويجب على مستخدمي TTY الاتصال على الرقم 1-877-486-2048.

- إدارة الأسرة والخدمات الاجتماعية (FSSA) في Indiana مدير ADA على الرقم 1-317-653-5603، أو البريد الإلكتروني ADA@fssa.in.gov.

- مكتب الحقوق المدنية التابع لوزارة الصحة والخدمات الإنسانية الأمريكية على الرقم 1-800-368-1019. يرجى من مستخدمي TTY الاتصال بالرقم 1-800-537-7697 لتقديم شكوى أو معرفة المزيد عن حقوقك، تفضل بزيارة: www.hhs.gov/ocr/complaints/index.html



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. သင့်လိုအပ်ချက်များနှင့် ကိုက်ညီသော နည်းလမ်းဖြင့် ဝန်ဆောင်မှုများနှင့် အချက်အလက်များကို ရယူရန် သင့်အခွင့်အရေး

အင်္ဂလိပ်စာကျွမ်းကျင်မှု အကန့်အသတ်ရှိသူများ၊ စာဖတ်စွမ်းရည် အကန့်အသတ်ရှိသူများ၊ အကြားအာရုံ ချို့တဲ့သူများ သို့မဟုတ် ယဉ်ကျေးမှုနှင့် လူမျိုးစုနောက်ခံ မတူညီသူများ အပါအဝင် ဆေးဖက်ဆိုင်ရာနှင့် ဆေးဖက်ဆိုင်ရာ မဟုတ်သော ဝန်ဆောင်မှု အားလုံးကို ယဉ်ကျေးမှုနှင့် ကိုက်ညီပြီး လက်လှမ်းမီသော နည်းလမ်းဖြင့် သင့်အား ပေးအပ်ကြောင်း ကျွန်ုပ်တို့ သေချာစေရပါမည်။ ကျွန်ုပ်တို့ အစီအစဉ်၏ အကျိုးခံစားခွင့်များနှင့် သင့်အခွင့်အရေးများအကြောင်းကို သင်နားလည်နိုင်သည့် နည်းလမ်းဖြင့်လည်း သင့်အား ပြောပြရပါမည်။ သင်သည် ကျွန်ုပ်တို့၏ အစီအစဉ်တွင် ပါဝင်နေသရွေ့နှစ်စဉ် သင့်တွင်ရှိသည့် အခွင့်အရေးများကို ကျွန်ုပ်တို့ဘက်မှ သင့်အား မပျက်မကွက် အသိပေးရမည်။

- သင်နားလည်နိုင်သော နည်းလမ်းဖြင့် အချက်အလက်များရယူရန်၊ အဖွဲ့ဝင် ဝန်ဆောင်မှုများသို့ ဖုန်းခေါ်ဆိုပါ။ ကျွန်ုပ်တို့အစီအစဉ်တွင် မတူညီသော ဘာသာစကားများဖြင့် မေးခွန်းများကို ဖြေဆိုရန် ရရှိနိုင်သော အခမဲ့စကားပြန်ဝန်ဆောင်မှုများ ရှိပါသည်။
- ကျွန်ုပ်တို့၏အစီအစဉ်သည် အင်္ဂလိပ်ဘာသာစကား မဟုတ်သော အာရဗီ၊ မြန်မာ၊ တရုတ်၊ ခမာ၊ ကိုရီးယား၊ စပိန်နှင့် ဗီယက်နမ် အပါအဝင် အခြားဘာသာစကားများဖြင့် စာလုံးကြီးဖြင့် ပုံနှိပ်စာများ၊ မျက်မမြင်စာ သို့မဟုတ် အသံဖိုင်ကဲ့သို့သော ဖော်မတ်များဖြင့်လည်း သင့်အား ပေးနိုင်ပါသည်။ ဤအခြားပုံစံများထဲမှ တစ်ခုခုဖြင့် ရယူရန် အဖွဲ့ဝင် ဝန်ဆောင်မှုများထံသို့ 1-833-412-4405 (TTY: 711) မှတစ်ဆင့် ဖုန်းခေါ်ဆိုပါ သို့မဟုတ် Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187, Atlanta, GA 30348-5187 သို့ စာရေးသားပေးပို့ပါ။
 - ဖုန်းခေါ်ဆိုသည့်အခါ ဤအမှာစာကို ပုံမှန်ပေးပို့ရမည့် အစီအစဉ်အဖြစ် သတ်မှတ်ပေးစေလိုခြင်း ရှိ၊ မရှိ ကျွန်ုပ်တို့အား တစ်ပါတည်း ပြောကြားပေးပါ။ ဆိုလိုသည်မှာ ကျွန်ုပ်တို့သည် စာရွက်စာတမ်းများကို သင်တောင်းဆိုထားသော ပုံစံနှင့် ဘာသာစကားဖြင့် နှစ်စဉ် ပေးပို့သွားပါမည်။
 - သင့်အနေဖြင့် ပုံမှန်ပေးပို့ရမည့် အစီအစဉ်ကို ပြောင်းလဲရန် သို့မဟုတ် ပယ်ဖျက်ရန်လည်း ကျွန်ုပ်တို့ထံ ဖုန်းခေါ်ဆိုနိုင်ပါသည်။



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- သင်၏စာရွက်စာတမ်းများကို အွန်လိုင်းဖြစ်သော www.anthem.com တွင်လည်း ရှာဖွေနိုင်ပါသည်။

သင့်အနေဖြင့် ဘာသာစကားပြဿနာများ သို့မဟုတ် မသန်စွမ်းမှုကြောင့် ကျွန်ုပ်တို့၏အစီအစဉ်မှ အချက်အလက်များ ရယူရာတွင် အခက်အခဲရှိပြီး တိုင်ကြားလိုပါက အောက်ပါဖုန်းနံပါတ်သို့ ဖုန်းဆက်ပါ-

- Medicare သို့ 1-800-MEDICARE (1-800-633-4227)။ TTY အသုံးပြုသူများသည် 1-877-486-2048 သို့ ဖုန်းခေါ်ဆိုသင့်သည်။
- Indiana မိသားစုနှင့် လူမှုရေးဝန်ဆောင်မှု စီမံခန့်ခွဲရေး (FSSA) ADA ဒါရိုက်တာထံ 1-317-653-5603 သို့ ဆက်သွယ်ပါ သို့မဟုတ် ADA@fssa.in.gov သို့ အီးမေးလ်ပို့ပါ။
- အမေရိကန်ပြည်ထောင်စု ကျန်းမာရေးနှင့် လူသားဝန်ဆောင်မှုဌာန အရပ်ဘက်အခွင့်အရေးရုံးသို့ 1-800-368-1019။ TTY အသုံးပြုသူများသည် 1-800-537-7697 သို့ ဖုန်းခေါ်ဆိုသင့်သည်။ တိုင်ကြားချက်တင်သွင်းရန် သို့မဟုတ် သင့်အခွင့်အရေးများအကြောင်း ပိုမိုလေ့လာရန် ဖော်ပြပါနေရာသို့ ဝင်ရောက်ကြည့်ရှုပါ- www.hhs.gov/ocr/complaints/index.html။



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. 您有權以所需方式獲得服務和資訊

我們必須確保**所有**臨床和非臨床服務均以符合文化要求且易於理解的方式提供給您，包括英語能力有限、閱讀能力有限、聽力障礙或具有不同文化和種族背景的人。我們還必須以您能夠瞭解的方式告知您本計劃的福利以及您的權利。在您加入本計劃期間，我們必須每年均將您的權利告知您。

- 如欲以您能夠瞭解的方式取得資訊，請致電會員服務部。我們的計劃提供免費口譯服務，可以用不同語言回答問題。
- 本計劃也給予您英語以外的語言（包括阿拉伯語、緬甸語、中文、高棉語、韓語、西班牙語和越南語）和大型字體印刷、點字或音訊格式的資料。要取得上述任一替代格式的材料，請致電會員服務部：1-833-412-4405 (TTY: 711) 或致函：Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187, Atlanta, GA 30348-5187。
 - 致電時，請告知我們您是否希望這是一項常規訂單。這意味著我們每年都會以您要求的格式和語言發送相同的文件。
 - 您也可以致電我們更改或取消長期訂單。
 - 您也可以從 www.anthem.com 在線上尋找您的文件。

如果您因語言問題或殘障而無法從我們的計劃中獲得資訊，並且您想提交投訴，請致電：

- Medicare，電話是 1-800-MEDICARE (1-800-633-4227)。TTY 用戶應致電 1-877-486-2048。
- Indiana 家庭和社會服務管理局 (FSSA) ADA 總監，致電 1-317-653-5603，或發送電子郵件至 ADA@fssa.in.gov。
- 美國衛生與大眾服務部民權辦公室，電話是 1-800-368-1019。TTY 使用者請撥打 1-800-537-7697。要提出投訴或瞭解有關您的權利的更多資訊，請瀏覽：
www.hhs.gov/ocr/complaints/index.html。



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. អ្នកមានសិទ្ធិទទួលបានសេវាកម្ម និងព័ត៌មានតាមមធ្យោបាយណាមួយដែលអ្នកពេញចិត្ត

យើងត្រូវតែធានាថាសេវាកម្មទាំងអស់ ទាំងសេវាកម្មគ្លីនិក និងមិនមែនគ្លីនិក ត្រូវបានផ្តល់ជូនអ្នកតាមលក្ខណៈរហ័ស និងអាចចូលប្រើបាន រួមទាំងសម្រាប់អ្នកដែលមានជំនាញភាសាអង់គ្លេសមានកម្រិត ជំនាញមានមានកម្រិត អសមត្ថភាពខាងការស្តាប់ ឬអ្នកដែលមានប្រវត្តិរូបរាងកាយ និងជាតិសាសន៍ចម្រុះ។ យើងក៏ត្រូវប្រាប់អ្នកអំពីអត្ថប្រយោជន៍នៃគម្រោងរបស់យើង និងសិទ្ធិរបស់អ្នកតាមវិធីដែលអ្នកអាចយល់បាន។ យើងត្រូវប្រាប់អ្នកឱ្យបានដឹងពីសិទ្ធិនានានៅក្នុងឆ្នាំនីមួយៗដែលអ្នកស្ថិតនៅក្នុងគម្រោងរបស់យើង។

- ដើម្បីទទួលបានព័ត៌មានក្នុងទម្រង់ដែលអ្នកអាចយល់បាន សូមទូរសព្ទទៅផ្នែកបម្រើសេវាសមាជិក។ គម្រោងរបស់យើងមានសេវាកម្មបកប្រែផ្ទាល់មាត់ភាគីទីបីដែលអាចឆ្លើយសំណួរជាភាសាផ្សេងៗ។
- គម្រោងរបស់យើងក៏អាចផ្តល់ជូនអ្នកនូវឯកសារជាភាសាផ្សេងក្រៅពីភាសាអង់គ្លេស រួមមានភាសាអារ៉ាប់ ភូមា ចិន ខ្មែរ កូរ៉េ អេស្ប៉ាញ និងវៀតណាម និងជាទម្រង់ផ្សេងៗដូចជាអក្សរពុម្ពធំ អក្សរស្លាប ឬសំឡេងផងដែរ។ ដើម្បីទទួលបានឯកសារក្នុងទម្រង់ជំនួសណាមួយក្នុងចំណោមទម្រង់ទាំងនេះ សូមទូរសព្ទទៅសេវាកម្មសមាជិកតាមរយៈលេខ 1-833-412-4405 (TTY: 711) ឬសរសេរទៅកាន់ Anthem I PathWays Dual Care Advantage (HMO D-SNP) PO Box 105187, Atlanta, GA 30348-5187។
 - នៅពេលហៅទូរសព្ទ សូមប្រាប់យើងឱ្យដឹង ប្រសិនបើអ្នកចង់ដាក់វាជាសំណើអចិន្ត្រៃយ៍។ មានន័យថា យើងនឹងផ្ញើឯកសារដូចគ្នាទៅតាមទម្រង់ និងភាសាដែលអ្នកបានស្នើសុំជារៀងរាល់ឆ្នាំ។
 - អ្នកក៏អាចទូរសព្ទទៅយើងខ្ញុំដើម្បីផ្លាស់ប្តូរ ឬបញ្ឈប់សំណើអចិន្ត្រៃយ៍ផងដែរ។
 - អ្នកក៏អាចស្វែងរកឯកសាររបស់អ្នកលើអ៊ីនធឺណិតបានផងដែរតាមរយៈគេហទំព័រ www.anthem.com។

ប្រសិនបើអ្នកមានបញ្ហាក្នុងការទទួលបានព័ត៌មានពីគម្រោងរបស់យើង ដោយសារតែបញ្ហាភាសា ឬពិការភាព ហើយអ្នកចង់ដាក់ពាក្យបណ្តឹង សូមហៅទូរសព្ទទៅ៖

- Medicare តាមរយៈលេខ 1-800-MEDICARE (1-800-633-4227)។ អ្នកប្រើប្រាស់ TTY គួរទូរសព្ទទៅលេខ 1-877-486-2048។
- នាយក ADA នៃរដ្ឋបាលសេវាគ្រួសារ និងសង្គមរដ្ឋ Indiana (FSSA) តាមរយៈលេខ 1-317-653-5603 ឬអ៊ីមែល ADA@fssa.in.gov។
- ការិយាល័យសិទ្ធិស៊ីវិលនៃក្រសួងសុខាភិបាល និងសេវាបន្តស្វ័យជាតិរបស់អាមេរិកតាមរយៈលេខ 1-800-368-1019។ អ្នកប្រើប្រាស់ TTY គួរតែទូរសព្ទទៅលេខ 1-800-537-7697។ ដើម្បីដាក់ពាក្យបណ្តឹង ឬស្វែងយល់បន្ថែមអំពីសិទ្ធិរបស់អ្នក សូមចូលទៅកាន់៖ www.hhs.gov/ocr/complaints/index.html។



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

A. 가입자는 요구 사항에 맞는 방식으로 서비스와 정보를 얻을 권리를 가집니다.

당사는 모든 임상 및 비임상 서비스가 영어 구사력이 낮은 사람, 읽기 능력이 낮은 사람, 청각 장애가 있는 사람, 문화나 민족적 배경이 다양한 사람을 포함하여 문화적으로 적합하고 접근 가능한 방식으로 제공되도록 해야 합니다. 가입자가 이해할 수 있는 방법으로 플랜의 혜택 및 가입자 권리를 설명해야 합니다. 또한 가입자가 저희 플랜에 가입한 후 매년 가입자의 권리에 대해 알려야 합니다.

- 가입자가 이해할 수 있는 방식으로 정보를 얻으려면 가입자 서비스부로 전화해 주십시오. 저희 플랜에는 다양한 언어로 질문에 답변해줄 통역사 서비스가 있습니다.
- 저희 플랜은 아랍어, 버마어, 중국어, 크메르어, 한국어, 스페인어, 베트남어 등 영어 이외의 언어와 큰 활자, 점자, 오디오 등의 형식으로도 자료를 제공해 드릴 수 있습니다. 이러한 대체 형식으로 자료를 받으시려면 가입자 서비스부 1-833-412-4405 (TTY: 711)번으로 전화하시거나 Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187, Atlanta, GA 30348-5187로 우편을 보내 주십시오.
 - 전화를 거실 때, 형식 또는 언어에 대한 귀하의 요청이 앞으로도 상시 지시로 적용되기를 원하는지 알려주십시오. 그렇게 원하시면 요청하신 형식과 언어로 매년 동일한 서류를 보내드릴 것입니다.
 - 상시 지시를 변경하거나 취소하려면 저희에게 전화하십시오.
 - 서류는 www.anthem.com에서 온라인으로도 확인하실 수 있습니다.

언어 문제나 장애로 인해 저희 플랜으로부터 정보를 얻는 데 문제가 있어 불만을 제기하실 경우, 연락하실 수 있는 전화 번호는 다음과 같습니다.

- Medicare, 1-800-MEDICARE (1-800-633-4227). TTY 사용자는 1-877-486-2048번을 이용해 주십시오.
- Indiana 가족 및 사회 복지 관리국(FSSA) ADA 국장에게 1-317-653-5603으로 전화하거나 ADA@fssa.in.gov로 이메일을 보내십시오.
- 미국 보건복지부 민권 담당국, 1-800-368-1019. TTY 사용자는 1-800-537-7697번을 이용해 주십시오. 불만을 제기하거나 귀하의 권리에 대해 자세히 알아보시려면 다음을 방문해 주십시오. www.hhs.gov/ocr/complaints/index.html.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

Debemos asegurarnos de que **todos** los servicios, tanto clínicos como no clínicos, se le brinden de una manera culturalmente competente y accesible, incluso para aquellos con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva o aquellos con diversos orígenes étnicos y culturales. También debemos informarle sobre los beneficios del plan y sus derechos de manera que pueda entender. Debemos brindarle información sobre sus derechos cada año que usted esté en nuestro plan.

- Para obtener información que pueda entender, llame a Servicios para Miembros. Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder las preguntas en diferentes idiomas.
- Nuestro plan también puede entregarle materiales en idiomas diferentes al inglés, como el árabe, el birmano, el chino, el khmer, el coreano, el español y el vietnamita, y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame a Servicios para Miembros al 1-833-412-4405 (TTY: 711) o escriba a Anthem | PathWays Dual Care Advantage (HMO D-SNP), P.O. Box 105187, Atlanta, GA 30348-5187.
 - Cuando llame, indique si se trata de un pedido regular. Eso quiere decir que enviaremos los mismos documentos en el formato e idioma solicitados todos los años.
 - También puede llamarnos para cambiar o cancelar el pedido regular.
 - También puede encontrar los documentos en línea en www.anthem.com.

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

- Medicare al 1-800-MEDICARE (1-800-633-4227). Los usuarios de TTY deben llamar al 1-877-486-2048.
- Llame al Director de ADA de la Administración de Servicios Sociales y Familiares de Indiana (FSSA) al 1-317-653-5603, o envíe un correo electrónico a ADA@fssa.in.gov.
- La Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697. Para presentar una queja u obtener más información sobre sus derechos, visite www.hhs.gov/ocr/complaints/index.html.



If you have questions, please call Anthem | PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. Quyền được nhận các dịch vụ và thông tin theo cách phù hợp với nhu cầu của quý vị

Chúng tôi phải đảm bảo **tất cả** các dịch vụ, cả lâm sàng và phi lâm sàng, đều được cung cấp cho quý vị theo cách phù hợp với văn hóa và dễ tiếp cận, kể cả đối với những người có khả năng sử dụng Tiếng Anh hạn chế, kỹ năng đọc hạn chế, người khiếm thính hoặc những người có nguồn gốc văn hóa và dân tộc đa dạng. Chúng tôi cũng phải cho quý vị biết các quyền lợi của chương trình của chúng tôi và quyền của quý vị theo cách mà quý vị có thể hiểu được. Chúng tôi phải thông báo về các quyền của quý vị mỗi năm khi quý vị tham gia chương trình của chúng tôi.

- Để được nhận thông tin theo cách mà quý vị có thể hiểu được, xin gọi cho Ban Dịch vụ Thành viên. Chương trình của chúng tôi có các dịch vụ thông dịch viên miễn phí để trả lời các câu hỏi bằng các ngôn ngữ khác nhau.
- Chương trình của chúng tôi cũng có thể cung cấp cho quý vị tài liệu bằng các ngôn ngữ khác ngoài Tiếng Anh, bao gồm Tiếng Ả Rập, Tiếng Miến Điện, Tiếng Trung, Tiếng Khmer, Tiếng Hàn, Tiếng Tây Ban Nha và Tiếng Việt, cũng như ở các định dạng như bản in cỡ chữ lớn, chữ nổi Braille hoặc âm thanh. Để nhận tài liệu ở một trong các định dạng thay thế này, vui lòng gọi cho Ban Dịch vụ Thành viên theo số 1-833-412-4405 (TTY: 711) hoặc viết thư đến Anthem I PathWays Dual Care Advantage (HMO D-SNP) P.O. Box 105187, Atlanta, GA 30348-5187.
 - Khi gọi điện, hãy cho chúng tôi biết nếu quý vị muốn yêu cầu lệnh thường trực. Điều này có nghĩa là hàng năm chúng tôi sẽ gửi các tài liệu tương tự theo định dạng và ngôn ngữ yêu cầu.
 - Quý vị cũng có thể gọi cho chúng tôi để thay đổi hoặc hủy bỏ yêu cầu lệnh thường trực.
 - Quý vị cũng có thể tìm tài liệu của mình trực tuyến tại www.anthem.com.

Nếu quý vị gặp khó khăn khi tiếp nhận thông tin từ chương trình chúng tôi do bất đồng ngôn ngữ hay khuyết tật và quý vị muốn khiếu nại, vui lòng gọi:

- Medicare theo số 1-800-MEDICARE (1-800-633-4227). Người dùng TTY xin gọi 1-877-486-2048.
- Giám Đốc phụ trách Đạo Luật Người Mỹ Khuyết Tật (ADA) của Cơ Quan Quản Lý Dịch Vụ Xã Hội và Gia Đình Indiana (FSSA) theo số 1-317-653-5603 hoặc qua email ADA@fssa.in.gov.
- Văn phòng Dân Quyền thuộc Bộ Y tế và Dịch vụ Nhân sinh Hoa Kỳ theo số 1-800-368-1019. Người dùng TTY xin gọi 1-800-537-7697. Để nộp đơn khiếu nại hoặc tìm hiểu thêm về quyền của quý vị, vui lòng truy cập: www.hhs.gov/ocr/complaints/index.html.



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

You have rights as a member of our plan.

- You have the right to choose a primary medical provider (PMP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PMP and how to choose a PMP in **Chapter 3** of your *Member Handbook*.
 - Call Member Services or go to the *Provider and Pharmacy Directory* to learn more about network providers and which doctors are accepting new patients.
- We **don't** require you to get referrals.
- You have the right to get covered services from network providers within a reasonable amount of time.
 - This includes the right to get timely services from specialists.
 - If you can't get services within a reasonable amount of time, we must pay for out-of-network care.
- You have the right to get emergency services or care that is urgently needed without prior authorization (PA).
- You have the right to get your prescriptions filled at any of our network pharmacies without long delays.
- You have the right to know when you can use an out-of-network provider. To learn about out-of-network providers, refer to **Chapter 3** of your *Member Handbook*.
- When you first join our plan, you have the right to keep your current providers and service authorizations for up to 12 months if certain conditions are met. To learn more about keeping your providers and service authorizations, refer to **Chapter 1** of your *Member Handbook*.
- You have the right to make your own healthcare decisions with help from your care team and care coordinator.

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

C1. How we protect your PHI

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

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

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

- We must release PHI to government agencies checking on our plan’s quality of care.
- We may release PHI if ordered by a court.
- We must give Medicare your PHI including information about your Medicare Part D drugs. If Medicare releases your PHI for research or other uses, they do it according to federal laws.

C2. Your right to look at your medical records

- You have the right to look at your medical records and to get a copy of your records.
- You have the right to ask us to update or correct your medical records. If you ask us to do this, we work with your health care provider to decide if changes should be made.
- You have the right to know if and how we share your PHI with others for any purposes that aren’t routine.

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

C3. Notice of Privacy Practices

Below is the Notice of Privacy Practices as of August 2026.

Notice of privacy practices

Important information about your rights and our responsibilities



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

Your personal information

Your 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. 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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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 healthcare you get through your plan.

Healthcare operations: We collect, use and share PHI for our healthcare operations.

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

Examples of ways we use your information:

- We keep information on file about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your doctor or hospital so that they may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to help you with services for conditions like asthma, diabetes or traumatic injury.
- We may collect and use publicly and/or commercially available data about you to support you and help you get health plan benefits and services.
- We may use PHI with technology to support and enable services provided to you.
- We may use your PHI to create, use or share de-identified data as allowed by HIPAA.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, healthcare operations and treatment. If you don't want your PHI to be shared in these situations, visit [anthem.com/privacy](https://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:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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, disability status, sexual orientation and gender identity: We may collect, infer, receive and/or maintain race, ethnicity, language, disability status, 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, disability status, 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.

Please note Elevance Health and its subsidiaries comply with Executive Order 14168.

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 healthcare 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.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

- Ask for a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or sharing of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to us, we may not agree to a restriction (see “Your rights” above). If a law requires sharing your information, we don’t have to agree to your restriction.
- Call Member Services at the phone number on your ID card to use any of these rights. A representative can give you the address to send the request. They can also give you any forms we have that may help you with this process.

How we protect information

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

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

Potential impact of other applicable laws

HIPAA, the federal privacy law, generally doesn’t cancel other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to give you more privacy protections, then we must follow that law in addition to HIPAA. One example is with Substance Use Disorder (SUD) Information we may receive from Providers or programs regulated by federal law (42 CFR Part 2). All disclosures of such SUD information must comply with applicable Federal and State privacy laws, including 42 CFR Part 2. We are allowed to Use and Disclose SUD information for certain Treatment, Payment, and Health Care Operations activities. You have the right to consent to the disclosure of SUD information in certain circumstances. You can revoke this consent in writing at any time.

Your Part 2 SUD records (or someone’s testimony about what those records say) cannot be used or shared in a case against you in civil, criminal, administrative, or legislative proceedings unless:

- You give written permission, or
- A court orders the disclosure and the order is accompanied by a subpoena or similar legal requirement, and you (or the person holding your SUD records) are given notice and a chance to speak to the court before the records are shared.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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 Member Services phone number on your ID Card. You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by visiting <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>. We will not take action against you for filing a complaint.

Contact information

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

Copies and changes

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

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision is as of August 2026 as noted at the top of this sub-section.

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.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- 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>.

D. Our responsibility to give you information

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

If you don't speak English, we have interpreter services to answer questions you have about our plan. To get an interpreter, call Member Services. This is a free service to you. You can call Member Services and ask to have this information sent to you in Arabic, Armenian, Cambodian, Chinese, Farsi, French, French Creole, Hindi, Hmong, Italian, German, Japanese, Korean, Laotian, Mien, Polish, Portuguese, Punjabi, Russian, Spanish, Tagalog, Thai, Ukrainian, or Vietnamese. We can also give you information in large print, braille, data or audio CD.

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

- How to choose or change plans
- Our plan, including:
 - o financial information
 - o how plan members have rated us
 - o the number of appeals made by members
 - o how to leave our plan
- Our network providers and our network pharmacies, including:
 - o how to choose or change primary medical providers
 - o qualifications of our network providers and pharmacies
 - o how we pay providers in our network
- Covered services and drugs, including:
 - o services (refer to **Chapters 3 and 4** of your *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of your *Member Handbook*) covered by our plan
 - o limits to your coverage and drugs



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o rules you must follow to get covered services and drugs
- Why something is not covered and what you can do about it (refer to **Chapter 9** of your *Member Handbook*), including asking us to:
 - o put in writing why something is not covered
 - o change a decision we made
 - o pay for a bill you got

E. Inability of network providers to bill you directly

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

F. Your right to leave our plan

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

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

G. Your right to make decisions about your health care

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

G2. Your right to say what you want to happen if you can't make health care decisions for yourself

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

- Fill out a written form **giving someone the right to make health care decisions for you** if you ever can't make decisions for yourself.
- **Give your doctors written instructions** about how to handle your health care if you can't make decisions for yourself, including care you do **not** want.

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

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

- **Get the form.** You can get the form from your doctor, a lawyer, a legal services agency, or a social worker. Pharmacies and provider offices often have the forms. You can find a free form online and download it. You can also contact Member Services to ask for the form.
- **Fill out the form and sign it.** The form is a legal document. You should consider having a lawyer or someone else you trust, such as a family member or your PMP, help you complete it.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- **Give copies to people who need to know.** You should give a copy of the form to your doctor. You should also give a copy to the person you name to make decisions for you. You may want to give copies to close friends or family members. Keep a copy at home.
- If you are being hospitalized and you have a signed advance directive, **take a copy of it to the hospital.**
 - o The hospital will ask if you have a signed advance directive form and if you have it with you.
 - o If you don't have a signed advance directive form, the hospital has forms and will ask if you want to sign one.

You have the right to:

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

By law, no one can deny you care or discriminate against you based on whether you signed an advance directive. Call Member Services for more information.

G3. What to do if your instructions aren't followed

If you signed an advance directive and you think a doctor or hospital didn't follow the instructions in it, you can make a complaint with the State of Indiana Department of Health. If at any time you feel as if your/your loved one's advanced directive isn't being followed or respected you can file a complaint with our plan and the State of Indiana Department of Health (IDOH).

You have the right to:

- Call the Health Care Facility Complaint Program Report Line Toll-free at: 1-800-246-8909 (available during state business hours). Please leave a brief message regarding your concerns along with your name and phone number on the secure voicemail line.
- Submit a complaint online at: redcap.isdh.in.gov/surveys/?s=DCXFFLMPPE

All complaints are kept confidential. Under state law, the IDOH doesn't identify or release the name of the individual submitting the complaint. During the complaint investigation, all precautions will be taken to protect the identity of the complainant and any patient, resident or client who is the subject of the care issue.

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

If you think we treated you unfairly – and it **isn't** about discrimination for reasons listed in **Chapter 11** of this *Member Handbook* – or you want more information about your rights, you can call:

- Member Services.
- The Indiana SHIP program at 1-800-452-4800 (TTY 1-866-846-0139). For more details about Indiana SHIP, refer to **Chapter 2** of this *Member Handbook*.
- The Ombudsperson Program at 1-800-622-4484 (TTY 711). For more details about this program, refer to **Chapter 2** of this *Member Handbook*.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. (You can also read or download “Medicare Rights & Protections,” found on the Medicare website at www.medicare.gov/publications/11534-medicare-rights-and-protections.pdf.)

I. Your responsibilities as a plan member

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

- **Read this *Member Handbook*** to learn what our plan covers and the rules to follow to get covered services and drugs. For details about your:
 - o Covered services, refer to **Chapters 3 and 4** of this *Member Handbook*. Those chapters tell you what's covered, what isn't covered, what rules you need to follow, and what you pay.
 - o Covered drugs, refer to **Chapters 5 and 6** of this *Member Handbook*.
- **Tell us about any other health or drug coverage** you have. We must make sure you use all of your coverage options when you get health care. Call Member Services if you have other coverage.
- **Tell your doctor and other health care providers** that you're a member of our plan. Show your Member ID Card when you get services or drugs.
- **Help your doctors** and other health care providers give you the best care.
 - o Give them information they need about you and your health. Learn as much as you can about your health problems. Follow the treatment plans and instructions that you and your providers agree on.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- Make sure your doctors and other providers know about all the drugs you take. This includes prescription drugs, over-the-counter drugs, vitamins, and supplements.
- Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Work with your care coordinator** including completing an annual health risk assessment.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - Medicare Part A and Medicare Part B premiums. For most Anthem I PathWays Dual Care Advantage (HMO D-SNP) members, Indiana PathWays for Aging pays for your Medicare Part A premium and for your Medicare Part B premium.
 - **If you get any services or drugs that aren't covered by our plan, you must pay the full cost.** (Note: If you disagree with our decision to not cover a service or drug, you can make an appeal. Please refer to **Chapter 9** to learn how to make an appeal.)
- **Tell us if you move.** If you plan to move, tell us right away. Call Member Services.
 - **If you move outside of our service area, you can't stay in our plan.** Only people who live in our service area can be members of this plan. **Chapter 1** of this *Member Handbook* advises you about our service area.
 - We can help you find out if you're moving outside our service area. During a special enrollment period, you can switch to Original Medicare or enroll in a Medicare health or drug plan in your new location. We can tell you if we have a plan in your new area.
 - Tell Medicare and Indiana PathWays for Aging your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Indiana PathWays for Aging.
 - **If you move and stay in our service area, we still need to know.** We need to keep your membership record up to date and know how to contact you.
 - **If you move, tell Social Security (or the Railroad Retirement Board).**
- **Call Member Services for help if you have questions or concerns.**



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

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

Introduction

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

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

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

Office of the Long Term Care Ombudsman information/complaint line at 800-622-4484 or 317-232-7134.
Hours of Operation, Monday-Friday: 9 a.m.- 5 p.m. (local time)

- Mailing Address: 402 West Washington Street, Room W451 , Post Office Box 7083, MS 27
Indianapolis, Indiana 46207-7083
- FAX: 317-972-3285
- Email: **LongTermCareOmbudsman@ombudsman.IN.gov**

This program advocates for residents of:

- nursing homes
- assisted living facilities
- other long-term care settings



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

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

A1. About the legal terms

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

For example, we say:

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

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

B. Where to get help

B1. For more information and help

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

Help from your plan

You can call our plan at 1-833-412-4405 (TTY: 711) to help deal with a problem or answer questions.

Help from the Indiana State Health Insurance Assistance Program (SHIP)

You can call the Indiana State Health Insurance Assistance Program (SHIP) (800) 452-4800. You can also review their website at www.in.gov/ship/. Indiana State Health Insurance Assistance Program (SHIP) counselors can answer your questions and help you understand what to do about your problem. Indiana State Health Insurance Assistance Program (SHIP) isn't connected with us or with any insurance company or health plan. Indiana State Health Insurance Assistance Program (SHIP) has trained



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

counselors in every county, and services are free. The Indiana State Health Insurance Assistance Program (SHIP) phone number is 1-800-452-4800.

Help and information from Medicare

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

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

Help and information from Indiana PathWays for Aging

- Office of the Long-Term Care Ombudsman (for residents of nursing homes, assisted living facilities, and other long-term care settings)
 - 402 West Washington Street, Room W451
 - Post Office Box 7083, MS 27 Indianapolis, Indiana 46207-7083
 - Information/complaint line: 800-622-4484 or 317-232-7134
 - Fax number: 317-972-3285
 - Email: LongTermCareOmbudsman@ombudsman.IN.gov
- Commence Health (State QIO)
 - URL: www.commencehealthqio.cms.gov/en/states/indiana
 - Phone number: (888) 524 - 9900 TTY: Dial 711.
 - Fax: (855) 236-2423
 - Hours of Operation
 - Monday-Friday: 9 a.m. - 5 p.m. (local time)
 - Sat/Sun and Holidays: 10 a.m. - 4 p.m. (local time)
 - 24-hour voicemail service is available
- The Department of Family Resources (DFR)
 - 1-800-403-0864. TTY users should call 1-800-743-3333.
 - You can visit the Indiana Family and Social Services Administration (Medicaid) website (www.in.gov/medicaid/).



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o DFR also has offices in all 92 counties in Indiana, please look online or call to find the closest local office

C. Understanding Medicare and Indiana PathWays for Aging complaints and appeals in our plan

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

Sometimes Medicare and Indiana PathWays for Aging processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Indiana PathWays for Aging benefit. **Section F4** explains these situations.

D. Problems with your benefits

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

Is your problem or concern about your benefits or coverage?	
This includes problems about whether particular medical care (medical items, services and/or Part B drugs) are covered or not, the way they’re covered, and problems about payment for medical care.	
Yes. My problem is about benefits or coverage. Refer to Section E , “Coverage decisions and appeals.”	No. My problem isn’t about benefits or coverage. Refer to Section K , “How to make a complaint.”

E. Coverage decisions and appeals

The process for asking for a coverage decision and making an appeal deals with problems related to your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple we generally refer to medical items, services, and 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.

E1. Coverage decisions

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

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

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we may decide a service or drug isn't covered or is no longer covered for you by Medicare or Indiana PathWays for Aging. If you disagree with this coverage decision, you can make an appeal.

E2. Appeals

If we make a coverage decision and you aren't satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check if we followed all rules properly. Different reviewers than those who made the original unfavorable decision handle your appeal.

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

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

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

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- **Member Services** at the numbers at the bottom of the page.
- Indiana State Health Insurance Assistance Program (SHIP)
 - o Address: 311 W Washington St, Indianapolis, IN 46204
 - o Phone- (800) 452-4800
 - o Hours: 8 a.m. - 5 p.m.
- **Your doctor or other provider.** Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
- **A friend or family member.** You can name another person to act for you as your “representative” and ask for a coverage decision or make an appeal.
- **A lawyer.** You have the right to a lawyer, but **you aren’t required to have a lawyer** to ask for a coverage decision or make an appeal.
 - o Call your own lawyer, or get the name of a lawyer from the local bar association or other referral service. Some legal groups will give you free legal services if you qualify.

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

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

E4. Which section of this chapter can help you

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

F. Medical care

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

This section is about your benefits for medical care that's described in **Chapter 4** of this *Member Handbook* in the benefits chart. In some cases, different rules may apply to a Medicare Part B drug. When they do, we explain how rules for Medicare Part B drugs differ from rules for medical services and items.

F1. Using this section

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

1. You think we cover medical care you need but aren't getting.

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

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

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

3. You got medical care that you think we cover, but we won't pay.

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

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

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

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

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

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

F2. Asking for a coverage decision

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

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

- Calling: 1-833-412-4405 (TTY: 711).
- Faxing: 1-877-664-1504.
- Writing:
Anthem Blue Cross and Blue Shield
Coverage Determinations
P.O. Box 105187
Atlanta, GA 30348-5187

Standard coverage decision

When we give you our decision, we use the “standard” deadlines unless we agree to use the “fast” deadlines. A standard coverage decision means we give you an answer within:

- Seven calendar days or five business days (whichever comes first) after we get your request for a medical service or item that's subject to our prior authorization rules.
- **14 calendar days** after we get your request **for all other medical services or items**.
- 72 hours after we get your request for a Medicare Part B drug.

Fast coverage decision

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

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

- 48 hours after we get your request for a medical service or item.
- 24 hours after we get your request for a Medicare Part B drug.

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

- You're asking for coverage for medical items and/or services that you **didn't get**. You can't ask for a fast coverage decision about payment for items or services you already got.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.

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

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

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

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

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

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

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

F3. Making a Level 1 Appeal

To start an appeal, related to a denied service or item, or to continue a service or item you're already receiving, you, your doctor, or your representative must contact us. Call us at 1-833-412-4405.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-833-412-4405.

- If your doctor or other prescriber asks to continue a service or item you're already getting during your appeal, you may need to name them as your representative to act on your behalf.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

- If someone other than your doctor makes the appeal for you, include an Appointment of Representative form authorizing this person to represent you. You can get the form by visiting www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf.
- We can accept an appeal request without the form, but we can't begin or complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal:
 - We dismiss your request, and
 - We send you a written notice explaining your right to ask the IRO to review our decision to dismiss your appeal.
- You must ask for an appeal within 65 calendar days from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

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

- If you appeal a decision we made about coverage for care, you and/or your doctor decide if you need a fast appeal.

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

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

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

- If we decide to change or stop coverage for a service or item that you get, we send you a notice before we take action.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If you disagree with our decision, you can file a Level 1 Appeal.
- We continue covering the service or item if you ask for a Level 1 Appeal within ten calendar days of the date on our letter or by the intended effective date of the action, whichever is later.
 - If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
 - You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
 - If you don't appeal before these dates, then your service or item won't be continued while you wait for your appeal decision.

We consider your appeal and give you our answer.

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

There are deadlines for a fast appeal.

- When we use the fast deadlines, we must give you our answer **within 48 hours after we get your appeal**. We'll give you our answer sooner if your health requires it. If we deny a fast appeal we'll give you, your doctor, prescriber, or representative verbal confirmation of the denial.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
 - If we need extra days to make the decision, we tell you in writing.
 - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
 - If we don't give you an answer within 48 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter Section F4, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Indiana a Fair Hearing is called an Indiana State Fair Hearing.
- **If we say Yes to part or all of your request**, we must authorize or provide the coverage we agreed to provide within 72 hours after we get your appeal.
- **If we say No to part or all of your request**, we send your appeal to the IRO for a Level 2 Appeal.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 30 calendar days** after we get your appeal for coverage for services you didn't get.
- If your request is for a Medicare Part B drug you didn't get, we give you our answer **within seven calendar days** after we get your appeal or sooner if your health requires it.
- If you ask for more time or if we need more information that may benefit you, we **can take up to 14 more calendar days** if your request is for a medical item or service.
 - If we need extra days to make the decision, we tell you in writing.
 - If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
 - If you think we **shouldn't** take extra days, you can file a fast complaint about our decision. When you file a fast complaint, we give you an answer within 24 hours. For more information about making complaints, including fast complaints, refer to **Section K**.
 - If we don't give you an answer by the deadline or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter **Section F4**, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Indiana a Fair Hearing is called an Indiana State Fair Hearing.

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

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

- If we say **No** to part or all of what you asked for, we send you a letter.
- If your problem is about coverage of a Medicare service or item, the letter tells you that we sent your case to the IRO for a Level 2 Appeal. The IRO will notify you in writing when it gets your appeal.
- If your problem is about coverage of a Indiana PathWays for Aging service or item, the letter tells you how to file a Level 2 Appeal yourself.

F4. Making a Level 2 Appeal

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.
- If your problem is about a service or item that Indiana PathWays for Aging usually covers, you can file a Level 2 Appeal yourself. The letter tells you how to do this. We also include more information later in this chapter.
- If your problem is about a service or item that both Medicare and Indiana PathWays for Aging may cover, you automatically get a Level 2 Appeal with the IRO. You can also ask for an Indiana State Fair Hearing with the state.

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

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

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

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

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

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

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

- If you had a fast appeal to us at Level 1, you automatically get a fast appeal at Level 2. The IRO must give you an answer to your Level 2 Appeal **within 72 hours** of getting your appeal.
- If your request is for a medical item or service and the IRO needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The IRO can't take extra time to make a decision if your request is for a Medicare Part B drug.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

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

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

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

- If the IRO says Yes to part or all of a request for a medical item or service, we must::
 - Authorize the medical care coverage **within 72 hours, or**
 - Provide the service within **14 calendar days** after we get the IRO's decision for **standard requests, or**
 - Provide the service **within 72 hours** from the date we get the IRO's decision for **expedited requests.**
- If the IRO says Yes to part or all of a request for a Medicare Part B drug, we must authorize or provide the Medicare Part B drug under dispute:
 - **Within 72 hours** after we get the IRO's decision for **standard requests, or**
 - **Within 24 hours** from the date we get the IRO's decision for **expedited requests.**
- **If the IRO says No to part or all of your appeal**, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."
 - If your case meets the requirements, you choose whether you want to take your appeal further.
 - There are three additional levels in the appeals process after Level 2, for a total of five levels.
 - If your Level 2 Appeal is turned down and you meet the requirements to continue the appeals process, you must decide whether to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal.
 - An Administrative Law Judge (ALJ) or attorney adjudicator handles a Level 3 Appeal. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- When your problem is about a service or item Medicaid usually covers, or that's covered by both Medicare and Indiana PathWays for Aging.
- A Level 2 Appeal for services that Indiana PathWays for Aging usually covers is a Fair Hearing with the state. In Indiana PathWays for Aging, a Fair Hearing is called Indiana State Fair Hearing (State Fair Hearing). You must ask for a State Fair Hearing in writing or by phone **within 120 calendar days** of the date we sent the decision letter on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a State Fair Hearing.
- You can appeal by phone, by mail or fax, or online.
 - o Fax your appeal to: 317-232-4412
 - o Email your appeal to fssa.appeals@oalp.in.gov
 - o Mail your appeal to: Family and Social Services Administration
Office of Administrative Law Proceedings-FSSA Hearings
100 N. Senate Ave., Room N802 Indianapolis, IN 46204

The State Fair Hearing office gives you their decision in writing and explain the reasons.

- If the State Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the State Fair Hearing office says **No** to part or all of your appeal, it means they agree that we shouldn't approve your request (or part of your request) for coverage for medical care. This is called "upholding the decision" or "turning down your appeal."

If the IRO or State Fair Hearing office decision is **No** for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the **IRO**, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. **The letter you get from the IRO explains additional appeal rights you may have.**

The letter you get from the State Fair Hearing office describes the next appeal option.

Refer to **Section J** for more information about your appeal rights after Level 2.

F5. Payment problems

We don't allow our network providers to bill you for covered services and items. This is true even if we pay the provider less than the provider charges for a covered service or item. You're never required to pay the balance of any bill.

- If the service or item you paid for is covered and you followed all the rules, we'll send you or your provider the payment for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If you haven't paid for the service or item yet, we'll send the payment directly to the provider. When we send the payment, it's the same as saying **Yes** to your request for a coverage decision.
- If the service or item isn't covered or you didn't follow all the rules, we'll send you a letter telling you we won't pay for the service or item and explaining why.

If you don't agree with our decision not to pay, **you can make an appeal**. Follow the appeals process described in **Section F3**. When you follow these instructions, note:

- If you make an appeal for us to pay you back, we must give you our answer within 30 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we will send your case to the IRO. We'll send you a letter if this happens.

- If the IRO reverses our decision and says we should pay you, we must send the payment to you or to the provider within 30 calendar days. If the answer to your appeal is **Yes** at any stage of the appeals process after Level 2, we must send the payment to you or to the health care provider within 60 calendar days.
- If the IRO says **No** to your appeal, it means they agree that we shouldn't approve your request. This is called "upholding the decision" or "turning down your appeal." You'll get a letter explaining additional appeal rights you may have. Refer to **Section J** for more information about additional levels of appeal.

If our answer to your appeal is **No** and Indiana PathWays for Aging usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to **Section F4** for more information.

G. Medicare Part D drugs

Your benefits as a member of our plan include coverage for many drugs. Most of these are Medicare Part D drugs. There are a few drugs that Medicare Part D doesn't cover that Indiana PathWays for Aging may cover. **This section only applies to Medicare Part D drug appeals.** We'll say "drug" in the rest of this section instead of saying "Medicare Part D drug" every time. For drugs covered only by Medicaid follow the process in **Section E**.

To be covered, the drug must be used for a medically accepted indication. That means the drug is approved by the Food and Drug Administration (FDA) or supported by certain medical references. Refer to **Chapter 5** of this *Member Handbook* for more information about a medically accepted indication.

G1. Medicare Part D coverage decisions and appeals

Here are examples of coverage decisions you ask us to make about your Medicare Part D drugs:

- You ask us to make an exception, including asking us to:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o cover a Medicare Part D drug that isn't on our plan's *Drug List* or
- o set aside a restriction on our coverage for a drug (such as limits on the amount you can get)
- You ask us if a drug is covered for you (such as when your drug is on our plan's *Drug List* but we must approve it for you before we cover it)

NOTE: If your pharmacy tells you that your prescription can't be filled as written, the pharmacy gives you a written notice explaining how to contact us to ask for a coverage decision.

An initial coverage decision about your Medicare Part D drugs is called a “**coverage determination.**”

- You ask us to pay for a drug you already bought. This is asking for a coverage decision about payment.

If you disagree with a coverage decision we made, you can appeal our decision. This section tells you both how to ask for coverage decisions and how to make an appeal. Use the chart below to help you.

Which of these situations are you in?			
You need a drug that isn't on our <i>Drug List</i> or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our <i>Drug List</i> , and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won't cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	You can ask us for a coverage decision.	You can ask us to pay you back. (This is a type of coverage decision.)	You can make an appeal. (This means you ask us to reconsider.)
Start with Section G2 , then refer to Sections G3 and G4.	Refer to Section G4.	Refer to Section G4.	Refer to Section G5.

G2. Medicare Part D exceptions

If we don't cover a drug in the way you would like, you can ask us to make an “exception.” If we turn down your request for an exception, you can appeal our decision.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

Asking for coverage of a drug not on our Drug List or for removal of a restriction on a drug is sometimes called asking for a **“formulary exception.”**

Here are some examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a drug that isn't on our Drug List

2. Removing a restriction for a covered drug

- Extra rules or restrictions apply to certain drugs on our Drug List (refer to **Chapter 5** of your *Member Handbook* for more information).
- Extra rules and restrictions for certain drugs include:
 - Being required to use the generic version of a drug instead of the brand name drug.
 - Getting our approval in advance before we agree to cover the drug for you. This is sometimes called “prior authorization (PA).”
 - Being required to try a different drug first before we agree to cover the drug you ask for. This is sometimes called “step therapy.”
 - Quantity limits. For some drugs, there are restrictions on the amount of the drug you can have.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If we say **No** to your exception request, you can make an appeal. Refer to **Section G5** for information on making an appeal if we say **No**.

The next section tells you how to ask for a coverage decision, including an exception.

G4. Asking for a coverage decision, including an exception

- Ask for the type of coverage decision you want by calling 1-833-412-4405, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information about the claim.
- You or your doctor (or other prescriber) or someone else acting on your behalf can ask for a coverage decision. You can also have a lawyer act on your behalf.
- Refer to **Section E3** to find out how to name someone as your representative.
- You don't need to give written permission to your doctor or other prescriber to ask for a coverage decision on your behalf.
- If you want to ask us to pay you back for a drug, refer to **Chapter 7** of your *Member Handbook*.
- If you ask for an exception, give us a "supporting statement." The supporting statement includes your doctor or other prescriber's medical reasons for the exception request.
- Your doctor or other prescriber can fax or mail us the supporting statement. They can also tell us by phone and then fax or mail the statement.

If your health requires it, ask us for a "fast coverage decision."

We use the "standard deadlines" unless we agree to use the "fast deadlines."

- A **standard coverage decision** means we give you an answer within 72 hours after we get your doctor's statement.
- A **fast coverage decision** means we give you an answer within 24 hours after we get your doctor's statement.

A "fast coverage decision" is called an **"expedited coverage determination."**

You can get a fast coverage decision if:

- It's for a drug you didn't get. You can't get a fast coverage decision if you are asking us to pay you back for a drug you already bought.
- Your health or ability to function would be seriously harmed if we use the standard deadlines.

If your doctor or other prescriber tells us that your health requires a fast coverage decision, we agree and give it to you. We send you a letter that tells you.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If you ask for a fast coverage decision without support from your doctor or other prescriber, we decide if you get a fast coverage decision.
- If we decide that your medical condition doesn't meet the requirements for a fast coverage decision, we use the standard deadlines instead.
 - We send you a letter that tells you. The letter also tells you how to make a complaint about our decision.
 - You can file a fast complaint and get a response within 24 hours. For more information making complaints, including fast complaints, refer to **Section K**.

Deadlines for a fast coverage decision

- If we use the fast deadlines, we must give you our answer within 24 hours after we get your request. If you ask for an exception, we give you our answer within 24 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO. Refer to **Section G6** for more information about a Level 2 Appeal.
- If we say **Yes** to part or all of your request, we give you the coverage within 24 hours after we get your request or your doctor's supporting statement.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how you can make an appeal.

Deadlines for a standard coverage decision about a drug you didn't get

- If we use the standard deadlines, we must give you our answer within 72 hours after we get your request. If you ask for an exception, we give you our answer within 72 hours after we get your doctor's supporting statement. We give you our answer sooner if your health requires it.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.
- If we say **Yes** to part or all of your request, we give you the coverage within 72 hours after we get your request or your doctor's supporting statement for an exception.
- If we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

Deadlines for a standard coverage decision about a drug you already bought

- We must give you our answer within 14 calendar days after we get your request.
- If we don't meet this deadline, we send your request to Level 2 of the appeals process for review by an IRO.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If we say **Yes** to part or all of your request, we pay you back within 14 calendar days.
- **If** we say **No** to part or all of your request, we send you a letter with the reasons. The letter also tells you how to make an appeal.

G5. Making a Level 1 Appeal

An appeal to our plan about a Medicare Part D drug coverage decision is called a plan **“redetermination”**.

- Start your **standard** or **fast appeal** by calling 1-833-412-4405, writing, or faxing us. You, your representative, or your doctor (or other prescriber) can do this. Please include your name, contact information, and information regarding your appeal.
- You must ask for an appeal **within 65 calendar days** from the date on the letter we sent to tell you our decision.
- If you miss the deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good reasons are things like you had a serious illness or we gave you the wrong information about the deadline. Explain the reason why your appeal is late when you make your appeal.
- You have the right to ask us for a free copy of the information about your appeal. You and your doctor may also give us more information to support your appeal.

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

A fast appeal is also called an **“expedited redetermination.”**

- If you appeal a decision we made about a drug you didn’t get, you and your doctor or other prescriber decide if you need a fast appeal.
- Requirements for a fast appeal are the same as those for a fast coverage decision. Refer to **Section G4** for more information.

We consider your appeal and give you our answer.

- We review your appeal and take another careful look at all of the information about your coverage request.
- We check if we followed the rules when we said **No** to your request.
- We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal at Level 1



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If we use the fast deadlines, we must give you our answer **within 72 hours** after we get your appeal.
 - We give you our answer sooner if your health requires it.
 - If we don't give you an answer within 72 hours, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must provide the coverage we agreed to provide within 72 hours after we get your appeal.
- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

Deadlines for a standard appeal at Level 1

- If we use the standard deadlines, we must give you our answer **within seven calendar days** after we get your appeal for a drug you didn't get.
- We give you our decision sooner if you didn't get the drug and your health condition requires it. If you believe your health requires it, ask for a fast appeal.
 - If we don't give you a decision within seven calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.

If we say **Yes** to part or all of your request:

- We must **provide the coverage** we agreed to provide as quickly as your health requires, but **no later than seven calendar days** after we get your appeal.
- We must **send payment to you** for a drug you bought **within 30 calendar days** after we get your appeal.

If we say **No** to part or all of your request:

- We send you a letter that explains the reasons and tells you how you can make an appeal.
- We must give you our answer about paying you back for a drug you bought **within 14 calendar days** after we get your appeal.
 - If we don't give you a decision within 14 calendar days, we must send your request to Level 2 of the appeals process. Then an IRO reviews it. Refer to **Section G6** for information about the review organization and the Level 2 appeals process.
- If we say **Yes** to part or all of your request, we must pay you within 30 calendar days after we get your request.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If we say **No** to part or all of your request, we send you a letter that explains the reasons and tells you how you can make an appeal.

G6. Making a Level 2 Appeal

If we say **No** to your Level 1 Appeal, you can accept our decision or make another appeal. If you decide to make another appeal, you use the Level 2 Appeal appeals process. The **IRO** reviews our decision when we said **No** to your first appeal. This organization decides if we should change our decision.

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

To make a Level 2 Appeal, you, your representative, or your doctor or other prescriber must contact the IRO in writing and ask for a review of your case.

- If we say **No** to your Level 1 Appeal, the letter we send you includes **instructions about how to make a Level 2 Appeal** with the IRO. The instructions tell who can make the Level 2 Appeal, what deadlines you must follow, and how to reach the organization.
- When you make an appeal to the IRO, we send the information we have about your appeal to the organization. This information is called your “case file”. **You have the right to a free copy of your case file.**
- You have a right to give the IRO additional information to support your appeal.

The IRO reviews your Medicare Part D Level 2 Appeal and gives you an answer in writing. Refer to **Section F4** for more information about the IRO.

Deadlines for a fast appeal at Level 2

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

- If they agree to a fast appeal, they must give you an answer within 72 hours after getting your appeal request.
- If they say **Yes** to part or all of your request, we must provide the approved drug coverage within 24 hours after getting the IRO’s decision.

Deadlines for a standard appeal at Level 2

If you have a standard appeal at Level 2, the IRO must give you an answer:

- within seven calendar days after they get your appeal for a drug you didn’t get.
- within 14 calendar days after getting your appeal for repayment for a drug you bought.

If the IRO says **Yes** to part or all of your request:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- We must provide the approved drug coverage **within 72 hours** after we get the IRO's decision.
- We must pay you back for a drug you bought within 30 calendar days after we get the IRO's decision.
- If the IRO says **No** to your appeal, it means they agree with our decision not to approve your request. This is called "upholding the decision" or "turning down your appeal".

If the IRO says **No** to your Level 2 Appeal, you have the right to a Level 3 Appeal if the dollar value of the drug coverage you ask for meets a minimum dollar value. If the dollar value of the drug coverage you ask for is less than the required minimum, you can't make another appeal. In that case, the Level 2 Appeal decision is final. The IRO sends you a letter that tells you the minimum dollar value needed to continue with a Level 3 Appeal.

If the dollar value of your request meets the requirement, you choose if you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2.
- If the IRO says **No** to your Level 2 Appeal and you meet the requirement to continue the appeals process, you:
 - o Decide if you want to make a Level 3 Appeal.
 - o Refer to the letter the IRO sent you after your Level 2 Appeal for details about how to make a Level 3 Appeal.

An ALJ or attorney adjudicator handles a Level 3 Appeals. Refer to **Section J** for more information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of this *Member Handbook*.

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

- The day you leave the hospital is called your "discharge date."
- Your doctor or the hospital staff will tell you what your discharge date is.

If you think you're being asked to leave the hospital too soon or you're concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

H1. Learning about your Medicare rights

Within two days after you're admitted to the hospital, someone at the hospital, such as a nurse or caseworker, will give you a written notice called "An Important Message from Medicare about Your Rights." Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital.

If you don't get the notice, ask any hospital employee for it. If you need help, call Member Services at the numbers at the bottom of the page. You can also call 1 800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1 877-486-2048.

- **Read the notice** carefully and ask questions if you don't understand. The notice tells you about your rights as a hospital patient, including your rights to:
 - Get Medicare-covered services during and after your hospital stay. You have the right to know what these services are, who will pay for them, and where you can get them.
 - Be a part of any decisions about the length of your hospital stay.
 - Know where to report any concerns you have about the quality of your hospital care.
 - Appeal if you think you're being discharged from the hospital too soon.
- **Sign the notice** to show that you got it and understand your rights.
 - You or someone acting on your behalf can sign the notice.
 - Signing the notice **only** shows that you got the information about your rights. Signing does **not** mean you agree to a discharge date your doctor or the hospital staff may have told you.
- **Keep your copy** of the signed notice so you have the information if you need it.

If you sign the notice more than two days before the day you leave the hospital, you'll get another copy before you're discharged.

You can look at a copy of the notice in advance if you:

- Call Member Services at the numbers at the bottom of the page
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- Visit www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-maim.

H2. Making a Level 1 Appeal

To ask for us to cover your inpatient hospital services for a longer time, make an appeal. The Quality Improvement Organization (QIO) reviews the Level 1 Appeal to find out if your planned discharge date is medically appropriate for you.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

The QIO is a group of doctors and other health care professionals paid by the federal government. These experts check and help improve the quality for people with Medicare. They are not part of our plan.

In Indiana, the QIO is Commence Health BFCC-QIO. Call them at 1-888-524-9900/TTY: 1-888-985-8775. Contact information is also in the notice, “An Important Message from Medicare about Your Rights,” and in **Chapter 2**.

Call the QIO before you leave the hospital and no later than your planned discharge date.

- **If you call before you leave**, you can stay in the hospital after your planned discharge date without paying for it while you wait for the QIO’s decision about your appeal.
- **If you do not call to appeal**, and you decide to stay in the hospital after your planned discharge date, you may pay all costs for hospital care you get after your planned discharge date.

Ask for help if you need it. If you have questions or need help at any time:

- Call Member Services at the numbers at the bottom of the page.
- Call the Indiana State Health Insurance Assistance Program (SHIP)
- Phone- 1-800-452-4800 hours: 8 a.m. 5p.m.

Ask for a fast review. Act quickly and contact the QIO to ask for a fast review of your hospital discharge.

The legal term for “**fast review**” is “**immediate review**” or “**expedited review.**”

What happens during fast review

- Reviewers at the QIO ask you or your representative why you think coverage should continue after the planned discharge date. You aren’t required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that the hospital and our plan gave them.
- By noon of the day after reviewers tell our plan about your appeal, you get a letter with your planned discharge date. The letter also gives reasons why your doctor, the hospital, and we think that is the right discharge date that’s medically appropriate for you.

The legal term for this written explanation is the “**Detailed Notice of Discharge.**” You can get a sample by calling Member Services at the numbers at the bottom of the page or 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can also refer to a sample notice online at www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-maim.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Within one full day after getting all of the information it needs, the QIO give you their answer to your appeal.

If the QIO says **Yes** to your appeal:

- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They believe your planned discharge date is medically appropriate.
- Our coverage for your inpatient hospital services will end at noon on the day after the QIO gives you their answer to your appeal.
- You may have to pay the full cost of hospital care you get after noon on the day after the QIO gives you their answer to your appeal.
- You can make a Level 2 Appeal if the QIO turns down your Level 1 Appeal **and** you stay in the hospital after your planned discharge date.

H3. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900/TTY: 1-888-985-8775.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you stay in the hospital after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We must pay you back for hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We'll provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

I. Asking us to continue covering certain medical services

This section is only about three types of services you may be getting:

- home health care services
- skilled nursing care in a skilled nursing facility, **and**
- rehabilitation care as an outpatient at a Medicare-approved CORF. This usually means you're getting treatment for an illness or accident or you're recovering from a major operation.

With any of these three types of services, you have the right to get covered services for as long as the doctor says you need them.

When we decide to stop covering any of these, we must tell you **before** your services end. When your coverage for that service ends, we stop paying for it.

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

I1. Advance notice before your coverage ends

We send you a written notice that you'll get at least two days before we stop paying for your care. This is called the "Notice of Medicare Non-Coverage." The notice tells you the date when we'll stop covering your care and how to appeal our decision.

You or your representative should sign the notice to show that you got it. Signing the notice **only** shows that you got the information. Signing **doesn't** mean you agree with our decision.

I2. Making a Level 1 Appeal

If you think we're ending coverage of your care too soon, you can appeal our decision. This section tells you about the Level 1 Appeal process and what to do.

- **Meet the deadlines.** The deadlines are important. Understand and follow the deadlines that apply to things you must do. Our plan must follow deadlines too. If you think we're not meeting our deadlines, you can file a complaint. Refer to **Section K** for more information about complaints.
- **Ask for help if you need it.** If you have questions or need help at any time:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- o Call Member Services at the numbers at the bottom of the page.
- o Call the Indiana State Health Insurance Assistance Program (SHIP)
- o Phone- 1-800-452-4800 Hours: 8 a.m. 5p.m.
- **Contact the QIO.**
 - o Refer to **Section H2** or refer to **Chapter 2** of your *Member Handbook* for more information about the QIO and how to contact them.
 - o Ask them to review your appeal and decide whether to change our plan's decision.
- **Act quickly and ask for a "fast-track appeal."** Ask the QIO if it's medically appropriate for us to end coverage of your medical services.

Your deadline for contacting this organization

- You must contact the QIO to start your appeal by noon of the day before the effective date on the "Notice of Medicare Non-Coverage" we sent you.

The legal term for the written notice is **"Notice of Medicare Non-Coverage"**. To get a sample copy, call Member Services at the numbers at the bottom of the page or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or get a copy online at www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-Expedited-Determination-Notices.

What happens during a fast-track appeal

- Reviewers at the QIO ask you or your representative why you think coverage should continue. You aren't required to write a statement, but you may.
- Reviewers look at your medical information, talk with your doctor, and review information that our plan gave them.
- Our plan also sends you a written notice that explains our reasons for ending coverage of your services. You get the notice by the end of the day the reviewers inform us of your appeal.

The legal term for the notice explanation is **"Detailed Explanation of Non-Coverage"**.

- Reviewers tell you their decision within one full day after getting all the information they need.

If the QIO says **Yes** to your appeal:

- We'll provide your covered services for as long as they're medically necessary.

If the QIO says **No** to your appeal:



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- Your coverage ends on the date we told you.
- We stop paying our share of the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

13. Making a Level 2 Appeal

For a Level 2 Appeal, you ask the QIO to take another look at the decision they made on your Level 1 Appeal. Call them at 1-888-524-9900 or TTY: 1-888-985-8775.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for our share of the costs of care you got since the date when we said your coverage would end.
- We'll provide coverage for the care for as long as it's medically necessary.

If the QIO says **No** to your appeal:

- They agree with our decision to end your care and won't change it.
- They give you a letter that tells you what you can do if you want to continue the appeals process and make a Level 3 Appeal.

An ALJ or attorney adjudicator handles Level 3 Appeals. Refer to **Section J** for information about Level 3, 4, and 5 Appeals.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that is favorable to you.

- If we decide **to appeal** the decision, we send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the ALJ or attorney adjudicator's decision.
 - If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.
- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Medicare Appeals Council (Council) reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your Level 4 Appeal or denies our request to review a Level 3 Appeal decision favorable to you, we have the right to appeal to Level 5.

- If we decide **to appeal** the decision, we will tell you in writing.
- If we decide **not to appeal** the decision, we must authorize or provide you with the service within 60 calendar days after getting the Council's decision.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Indiana PathWays for Aging appeals

You also have other appeal rights if your appeal is about services or items that Indiana PathWays for Aging usually covers. The letter you get from the State Fair Hearing office will tell you what to do if you want to continue the appeals process.

For additional information on State Fair Hearings, use the following information to contact the Office of Administrative Law Proceedings using the following contact information: 100 N. Senate Ave., Room N802 Indianapolis, IN 46204, Fax: 317-232-4412, Email: fssa.appeals@oalp.in.gov.

J3. Appeal Levels 3, 4 and 5 for Medicare 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 on to additional levels of appeal. The written response you get to your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the ALJ or attorney adjudicator says **No** to your appeal, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal or if the Council denies the review request, the appeals process may not be over.

- If you decide **to accept** the decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

K. How to make a complaint

K1. What kinds of problems should be complaints

The complaint process is used for certain types of problems only, such as problems about quality of care, waiting times, coordination of care, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• You're unhappy with the quality of care, such as the care you got in the hospital.
Respecting your privacy	• You think that someone didn't respect your right to privacy or shared confidential information about you.
Disrespect, poor customer service, or other negative behaviors	• A health care provider or staff was rude or disrespectful to you. • Our staff treated you poorly. • You think you are being pushed out of our plan.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Complaint	Example
Accessibility and language assistance	- You cannot physically access the health care services and facilities in a doctor or provider's office. - Your doctor or provider doesn't provide an interpreter for the non-English language you speak (such as American Sign Language or Spanish). - Your provider does not give you other reasonable accommodations you need and ask for.
Waiting times	- You have trouble getting an appointment or wait too long to get it. - Doctors, pharmacists, or other health professionals, Customer Service, or other plan staff keep you waiting too long.
Cleanliness	You think the clinic, hospital or doctor's office isn't clean.
Information you get from us	- You think we failed to give you a notice or letter that you should've received. - You think written information we sent you is too difficult to understand.
Timeliness related to coverage decisions or appeals	- You think we don't meet our deadlines for making a coverage decision or answering your appeal. - You think that, after getting a coverage or appeal decision in your favor, we don't meet the deadlines for approving or giving you the service or paying you back for certain medical services. - You don't think we sent your case to the IRO on time.

There are different kinds of complaints. You can make an internal complaint and/or an external complaint. An internal complaint is filed with and reviewed by our plan. An external complaint is filed with and reviewed by an organization not affiliated with our plan. If you need help making an internal and/or external complaint, you can call 1-833-412-4405.

The legal term for "complaint" is **"grievance."**

The legal term for "making a complaint" is **"filing a grievance."**



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

K2. Internal complaints

To make an internal complaint, call Member Services at 1-833-412-4405. You can make the complaint at any time unless it's about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it within **60 calendar days** after you had the problem you want to complain about.

- If there's anything else you need to do, Member Services will tell you.
- You can also write your complaint and send it to us. If you put your complaint in writing, we'll respond to your complaint in writing.

The legal term for “fast complaint” is “**expedited grievance.**”

If possible, we answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we'll do that.

- We answer most complaints within 30 calendar days. If we don't make a decision within 30 calendar days because we need more information, we notify you in writing. We also provide a status update and estimated time for you to get the answer.
- If you make a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we automatically give you a “fast complaint” and respond to your complaint within 24 hours.
- If you make a complaint because we took extra time to make a coverage decision or appeal, we automatically give you a “fast complaint” and respond to your complaint within 24 hours.

If we don't agree with some or all of your complaint, we'll tell you and give you our reasons. We respond whether we agree with the complaint or not.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: www.medicare.gov/my/medicare-complaint. You do not need to file a complaint with Anthem I PathWays Dual Care Advantage (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan is not addressing your problem, you can also call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. The call is free.

Contact your State Medicaid Office to learn about your Medicaid plan options (telephone numbers are in **Chapter 2, Section 6** of the *Member Handbook*).



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you have not been treated fairly. For example, you can make a complaint about disability access or language assistance. The phone number for the OCR is 1-800-368-1019. TTY users should call 1-800-537-7697. You can visit www.hhs.gov/ocr for more information.

You may also contact the local OCR office at:

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

Customer Response Center: 1-800-368-1019

Fax: 202-619-3818

TTY: 1-800-537-7697

Email: OCRComplaint@hhs.gov

You may also have rights under the Americans with Disability Act (ADA) and under other laws that apply to organizations that get Federal funding, and any other rules that apply for any other reason. You can contact the ADA-IN State Affiliate at 1-260-969-7630 or the Great Lakes ADA Center at 1-800-949-4232 if you have a question about your rights or obligations under the Americans with Disabilities Act.

QIO

When your complaint is about quality of care, you have two choices:

- You can make your complaint about the quality of care directly to the QIO.
- You can make your complaint to the QIO and to our plan. If you make a complaint to the QIO, we work with them to resolve your complaint.

The QIO is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. To learn more about the QIO, refer to **Section H2** or refer to **Chapter 2** of this *Member Handbook*.

In Indiana, the QIO is called Commence Health BFCC-QIO. The phone number for Commence Health BFCC-QIO is Toll Free Beneficiary Helpline 1-888-524-9900/TTY: 1-888-985-8775.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 10: Ending your membership in our plan

Introduction

This chapter explains how you can end your membership with our plan and your health coverage options after you leave our plan. If you leave our plan, you will still be in the Medicare and Indiana PathWays for Aging programs as long as you are eligible. Key terms and their definitions appear in alphabetical order in the last chapter of your *Member Handbook*.

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. When you can end your membership in our plan

Most people with Medicare can end their membership during certain times of the year. Since you have Indiana PathWays for Aging, you have some choices to end your membership with our plan including any month of the year.

In addition, you may end your membership in our plan during the following periods each year:

- **The Open Enrollment Period**, which lasts from October 15 to December 7. If you choose a new plan during this period, your membership in our plan ends on December 31 and your membership in the new plan starts on January 1.
- **The Medicare Advantage (MA) Open Enrollment Period**, which lasts from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in a plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement. If you choose a new plan during this period, your membership in the new plan starts the first day of the next month.

There may be other situations when you're eligible to make a change to your enrollment. For example, when:

- you move out of our service area,
- your eligibility for Indiana PathWays for Aging or Extra Help changed **or**
- if you recently moved into, currently are getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your membership ends on the last day of the month that we get your request to leave our plan. For example, if we get your request on January 18, your coverage with our plan ends on January 31. If you enroll in another plan, your new coverage begins the first day of the next month (February 1, in this example).

If you leave our plan, you can get information about your:

- Medicare options in the table in **Section C1**.
- Medicaid services in **Section C2**.

You can get more information about how you can end your membership by calling:

- Member Services at the number at the bottom of this page. The number for TTY users is listed too.
- Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.
- The State Health Insurance Assistance Program (SHIP), Indiana State Health Insurance Assistance Program (SHIP) at 1-800-452-4800.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

NOTE: If you're in a drug management program (DMP), you may not be able to change plans. Refer to **Chapter 5** of this *Member Handbook* for information about drug management programs.

B. How to end your membership in our plan

If you decide to end your membership you can do so by enrolling in another Medicare plan or switch to Original Medicare. However, if you want to switch from our plan to Original Medicare but you haven't selected a separate Medicare drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services at the number at the bottom of this page if you need more information on how to do this.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users (people who have difficulty with hearing or speaking) should call 1-877-486-2048. When you call 1-800-MEDICARE, you can also enroll in another Medicare health or drug plan. More information on getting your Medicare services when you leave our plan is in the chart in **Section C1**.

C. How to get Medicare and Indiana PathWays for Aging services separately

You have choices about getting your Medicare and Medicaid services if you choose to leave our plan.

C1. Your Medicare services

You have three options for getting your Medicare services listed below any month of the year. You have an additional option listed below during certain times of the year including the **Open Enrollment Period** and the **Medicare Advantage Open Enrollment Period** or other situations described in **Section A**. By choosing one of these options, you automatically end your membership in our plan.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

1. You can change to: Another plan that provides your Medicare and most or all of your Medicaid benefits and services in one plan, also known as an integrated dual-eligible special needs plan (D-SNP) or a Program of All-inclusive Care for the Elderly (PACE) plan, if you qualify.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, additional information about PACE, including qualifying service areas, is available on the Program of All-Inclusive Care for the Elderly page at www.in.gov/fssa/ddars/bba/program-of-all-inclusive-care-for-the-elderly/ on the Indiana Family and Social Services (FSSA) Division of Aging website. If you need help or more information: • Call the Indiana SHIP at 1-800-452-4800. The SHIP’s central office line is 1-800-452-4800. For more information or to find a local SHIP office in your area, please visit www.in.gov/ship/. OR Enroll in a new integrated D-SNP. You’ll automatically be disenrolled from our Medicare plan when your new plan’s coverage begins. If you enroll into a new D-SNP, your Indiana PathWays for Aging plan will switch to the new D-SNP
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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

2. You can change to: Original Medicare with a separate Medicare drug plan	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the Indiana SHIP. The SHIP’s central office line is 1-800-452-4800. For more information or to find a local SHIP office in your area, please visit www.in.gov/ship/. OR Enroll in a new Medicare drug plan. You’ll automatically be disenrolled from our plan when your Original Medicare coverage begins. You’ll remain with the Managed Care Entity for your Indiana PathWays for Aging plan. No matter what Medicare plan the member selects, the PathWays program requires coordination of benefits to the greatest extent possible between the PathWays Medicaid health plan and the member's Medicare health plan.
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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

3. You can change to: Original Medicare without a separate Medicare drug plan if you have a valid disenrollment reason NOTE: 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 tell Medicare you don't want to join. You should only drop drug coverage if you have drug coverage from another source, such as an employer or union. If you have questions about whether you need drug coverage, call the Indiana SHIP. The SHIP's central office line is 1-800-452-4800. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. For more information or to find a local SHIP office in your area visit www.in.gov/ship/	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If you need help or more information: • Call the Indiana SHIP. The SHIP's central office line is 1-800-452-4800. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. For more information or to find a local SHIP office in your area, please visit www.in.gov/ship/. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. You'll remain with the Managed Care Entity for your Indiana PathWays for Aging plan. No matter what Medicare plan the member selects, the PathWays program requires coordination of benefits to the greatest extent possible between the PathWays Medicaid health plan and the member's Medicare health plan.
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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

4. You can change to: Any Medicare health plan during certain times of the year including the Open Enrollment Period and the Medicare Advantage Open Enrollment Period or other situations described in Section A.	Here is what to do: Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Additional information about PACE, including qualifying service areas, is available on the Program of All-Inclusive Care for the Elderly page at www.in.gov/fssa/ddars/bba/program-of-allinclusive-care-for-the-elderly/ on the Indiana Family and Social Services (FSSA) Division of Aging website. If you need help or more information: Call the Indiana SHIP. The SHIP’s central office line is 1-800-452-4800. Hours of operation are Monday through Friday, 8 a.m. to 5 p.m. For more information or to find a local SHIP office in your area, please visit www.in.gov/ship/. OR Enroll in a new Medicare plan. You’ll automatically be disenrolled from our Medicare plan when your new plan’s coverage begins. If you enroll into a new D-SNP, your Indiana PathWays for Aging plan will switch to the new D-SNP. No matter what Medicare plan the member selects, the PathWays program requires coordination of benefits to the greatest extent possible between the PathWays Medicaid health plan and the member's Medicare health plan.
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C2. Your Indiana PathWays for Aging services

For questions about how to get your Indiana PathWays for Aging services after you leave our plan, call 1-877-284-9294, or visit www.in.gov/pathways/. Ask how joining another plan or returning to Original Medicare affects how you get your Indiana PathWays for Aging coverage.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

D. Your medical items, services and drugs until your membership in our plan ends

If you leave our plan, it may take time before your membership ends and your new Medicare and Indiana PathWays for Aging coverage begins. During this time, you keep getting your drugs and health care through our plan until your new plan begins.

- Use our network providers to receive medical care.
- Use our network pharmacies including through our mail-order pharmacy services to get your prescriptions filled.
- If you're hospitalized on the day that your membership in Anthem I PathWays Dual Care Advantage (HMO D-SNP) ends, our plan will cover your hospital stay until you're discharged. This will happen even if your new health coverage begins before you're discharged.

E. Other situations when your membership in our plan ends

These are cases when we must end your membership in our plan:

- If there's a break in your Medicare Part A and Medicare Part B coverage.
- If you no longer qualify for Medicaid. Our plan is for people who qualify for both Medicare and Medicaid.
- If you move out of our service area.
- If you're away from our service area for more than six months.
 - If you move or take a long trip, call Member Services to find out if where you're moving or traveling to is in our plan's service area.
- If you go to jail or prison for a criminal offense.
- If you lie about or withhold information about other insurance you have for drugs.
- If you're not a United States citizen or national, or an eligible non-citizen.
 - You must be a United States citizen or national, or an eligible non-citizen to be a member of our plan.
 - The Centers for Medicare & Medicaid Services (CMS) notify us if you're not eligible to remain a member on this basis.
 - We must disenroll you if you don't meet this requirement.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

- If you lose your Indiana PathWays for Aging eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem I PathWays Dual Care Advantage (HMO D-SNP). When your Indiana PathWays for Aging coverage ends, we won't pay for your Indiana PathWays for Aging benefits. During this time, your costs may go up. You may have to pay Medicare premiums, copays, coinsurance, or deductibles that Medicaid used to pay for you. Your cost sharing for supplemental benefits from the plan will not increase.

In addition, if you lose your Indiana PathWays for Aging eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

For additional information about how a change in your Indiana PathWays for Aging eligibility may affect your benefits and cost sharing, please contact Member Services.

We'll assist you to regain your Indiana PathWays for Aging eligibility. If your Indiana PathWays for Aging eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us will continue. We'll resume paying for your Indiana PathWays for Aging benefits and your Medicare premiums, deductibles, copays, and coinsurance. In addition, we will restore any Part D prescription drug coverage and cost-sharing assistance for which you again qualify. If you can't regain Indiana PathWays for Aging within six months we'll disenroll you from Anthem I PathWays Dual Care Advantage (HMO D-SNP). If you regain Indiana PathWays for Aging eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.

We can make you leave our plan for the following reasons only if we get permission from Medicare and Medicaid first:

- If you intentionally give us incorrect information when you're enrolling in our plan and that information affects your eligibility for our plan.
- 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.
- If you let someone else use your Member ID Card to get medical care. (Medicare may ask the Inspector General to investigate your case if we end your membership for this reason.)

F. Rules against asking you to leave our plan for any health-related reason

We cannot ask you to leave our plan for any reason related to your health. If you think we're asking you to leave our plan for a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

G. Your right to make a complaint if we end your membership in our plan

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



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

decision to end your membership. You can also refer to **Chapter 9** of your *Member Handbook* for information about how to make a complaint.

H. How to get more information about ending your plan membership

If you have questions or would like more information on ending your membership, you can call Member Services at the number at the bottom of this page.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 11: Legal notices

Introduction

This chapter includes legal notices that apply to your membership in our plan. Key terms and their definitions appear in alphabetical order in the last chapter of this *Member Handbook*.

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If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

A. Notice about laws

Many laws apply to this *Member Handbook*. These laws may affect your rights and responsibilities even if the laws aren't included or explained in this *Member Handbook*. The main laws that apply are federal laws about the Medicare and Indiana PathWays for Aging programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. In addition, we do not unlawfully discriminate, exclude people, or treat them differently because of ancestry, ethnic group identification, gender identity, marital status, or medical condition.

If you want more information or have concerns about discrimination or unfair treatment:

- Call the Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019. TTY users can call 1-800-537-7697. You can also visit www.hhs.gov/ocr for more information.
- Call your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Ave., Suite 240
Chicago, IL 60601

- If you have a disability and need help accessing health care services or a provider, call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

C. Notice about Medicare as a second payer and Indiana PathWays for Aging as a payer of last resort

Sometimes someone else must pay first for the services we provide you. For example, if you're in a car accident or if you're injured at work, insurance or Workers Compensation must pay first.

We have the right and responsibility to collect for covered Medicare services for which Medicare isn't the first payer.

We comply with federal and state laws and regulations relating to the legal liability of third parties for health care services to members. We take all reasonable measures to ensure that Indiana PathWays for Aging is the payer of last resort.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout your *Member Handbook* with their definitions. The terms are listed in alphabetical order. If you can't find a term you're looking for or if you need more information than a definition includes, contact Member Services.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Activities of daily living (ADL): The things people do on a normal day, such as eating, using the toilet, getting dressed, bathing, or brushing teeth.

Administrative law judge: A judge that reviews a level 3 appeal.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who do not need hospital care and who are not expected to need more than 24 hours of care.

Appeal: A way for you to challenge our action if you think we made a mistake. You can ask us to change a coverage decision by filing an appeal. **Chapter 9** of your *Member Handbook* explains appeals, including how to make an appeal.

Behavioral health: An all-inclusive term referring to mental health and substance use disorder services.

Biological product: A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and cannot be copied exactly, so alternative forms are called biosimilars. (See also “Original biological product” and “Biosimilar”).

Biosimilar: A biological drug that is 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. (See “Interchangeable biosimilar”).

Brand name drug: A prescription drug that is made and sold by the company that originally made the drug. Brand name drugs have the same ingredients as the generic versions of the drugs. Generic drugs are usually made and sold by other drug companies.

Care coordinator: One main person who works with you, with the health plan, and with your care providers to make sure you get the care you need.

Care plan: Refer to “Individualized care plan.”

Care Plan Optional Services (CPO Services): Additional services that are optional under your Individualized Care Plan (ICP). These services are not intended to replace long-term services and supports that you are authorized to get under Indiana PathWays for Aging.

Care team: Refer to “Interdisciplinary care team.”

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of your *Member Handbook* explains how to contact CMS.

Complaint: A written or spoken statement saying that you have a problem or concern about your covered services or care. This includes any concerns about the quality of service, quality of your care, our network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical



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therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services.

Coverage decision: A decision about what benefits we cover. This includes decisions about covered drugs and services or the amount we pay for your health services. **Chapter 9** of your *Member Handbook* explains how to ask us for a coverage decision.

Covered drugs: The term we use to mean all of the prescription and over-the-counter (OTC) drugs covered by our plan.

Covered services: The general term we use to mean all of the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers.

Cultural competence training: Training that provides additional instruction for our health care providers that helps them better understand your background, values, and beliefs to adapt services to meet your social, cultural, and language needs.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Drug Management Program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications.

Drug tiers: Groups of drugs on our Drug List. Generic, brand name, or over-the-counter (OTC) drugs are examples of drug tiers. Every drug on the Drug List is in one of five tiers.

Dual eligible special needs plan (D-SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. Our plan is a D-SNP.

Durable medical equipment (DME): Certain items your doctor orders for use in your own home. Examples of these items are wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment and supplies, nebulizers, and walkers.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency.

Evidence of Coverage and Disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations.

Excluded services: Services that are not covered by this health plan.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

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

Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP): Health plan that serves individuals who are eligible for both Medicare and Medicaid. A FIDE SNP covers both Medicare and Medicaid under a single health plan. Our plan is a FIDE SNP.

Generic drug: A prescription drug approved by the federal government to use in place of a brand name drug. A generic drug has the same ingredients as a brand name drug. It's usually cheaper and works just as well as the brand name drug.

Grievance: A complaint you make about us or one of our network providers or pharmacies. This includes a complaint about the quality of your care or the quality of service provided by your health plan.

Health plan: An organization made up of doctors, hospitals, pharmacies, providers of long-term services, and other providers. It also has care coordinators to help you manage all your providers and services. All of them work together to provide the care you need.

Health risk assessment (HRA): A review of your medical history and current condition. It's used to learn about your health and how it might change in the future.

Home health aide: A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (like bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides don't have a nursing license or provide therapy.

Hospice: A program of care and support to help people who have a terminal prognosis live comfortably. A terminal prognosis means that a person has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less.

- An enrollee who has a terminal prognosis has the right to elect hospice.
- A specially trained team of professionals and caregivers provide care for the whole person, including physical, emotional, social, and spiritual needs.
- We're required to give you a list of hospice providers in your geographic area.

Improper/inappropriate billing: A situation when a provider (such as a doctor or hospital) bills you more than our cost-sharing amount for services. Call Member Services if you get any bills you don't understand.

Because we pay the entire cost for your services, you **don't** owe any cost-sharing. Providers shouldn't bill you anything for these services.

Independent review organization (IRO): An independent organization hired by Medicare that reviews a level 2 appeal. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com.

Indiana PathWays for Aging: This is the name of Indiana's Medicaid program. Indiana PathWays for Aging is run by the state and is paid for by the state and the federal government. It helps people with limited incomes and resources pay for long-term services and supports and medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Individualized care plan (ICP or Care plan): A plan for what services you will get and how you will get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Inpatient: A term used when you are formally admitted to the hospital for skilled medical services. If you're not formally admitted, you may still be considered an outpatient instead of an inpatient even if you stay overnight.

Integrated D-SNP: A dual-eligible special needs plan 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 known as full-benefit dually eligible individuals.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements related to the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Interdisciplinary care team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

Legend drugs: A "legend drug" is any medicine covered by Medicaid that you can only get if a doctor writes you a prescription.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The Drug List tells you if there are any rules you need to follow to get your drugs. The Drug List is sometimes called a "formulary".

Long-term services and supports (LTSS): Long-term services and supports help improve a long-term medical condition. Most of these services help you stay in your home so you don't have to go to a nursing facility or hospital. LTSS include Community-Based Services, Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to "Extra Help"

Mail Order Program: Some plans may offer a mail-order program that allows you to get up to a 3-month supply of your covered prescription drugs sent directly to your home. This may be a cost-effective and convenient way to fill prescriptions you take regularly.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Indiana PathWays for Aging is the Medicaid program for the State of Indiana.



If you have questions, please call Anthem I PathWays Dual Care Advantage (HMO D-SNP) at 1-833-412-4405 (TTY: 711). 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com.

Medically necessary: This describes services, supplies, or drugs you need to prevent, diagnose, or treat a medical condition or to maintain your current health status. This includes care that keeps you from going into a hospital or nursing facility. It also means the services, supplies, or drugs meet accepted standards of medical practice.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare or a managed care plan (refer to “Health plan”).

Medicare Advantage: A Medicare program, also known as “Medicare Part C” or “MA”, that offers MA plans through private companies. Medicare pays these companies to cover your Medicare benefits.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government.

Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all of the services covered by Medicare Part A and Medicare Part B.

Medicare diabetes prevention program (MDPP): A structured health behavior change program that provides training in long-term dietary change, increased physical activity, and strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.

Medicare-Medicaid enrollee: A person who qualifies for Medicare and Medicaid coverage. A Medicare-Medicaid enrollee is also called a “dually eligible individual”.

Medicare Part A: The Medicare program that covers most medically necessary hospital, skilled nursing facility, home health, and hospice care.

Medicare Part B: The Medicare program that covers services (such as lab tests, surgeries, and doctor visits) and supplies (such as wheelchairs and walkers) that are medically necessary to treat a disease or condition. Medicare Part B also covers many preventive and screening services.

Medicare Part C: The Medicare program, also known as “Medicare Advantage” or “MA”, that lets private health insurance companies provide Medicare benefits through an MA Plan.

Medicare Part D: The Medicare prescription drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient prescription drugs, vaccines, and some supplies not covered by Medicare Part A or Medicare Part B or Medicaid. Our plan includes Medicare Part D.

Medicare Part D drugs: Drugs covered under Medicare Part D. Congress specifically excludes certain categories of drugs from coverage under Medicare Part D. Medicaid may cover some of these drugs.

Medication Therapy Management (MTM): A distinct group of service or group of services provided by health care providers, including pharmacists, to ensure the best therapeutic outcomes for patients. Refer to **Chapter 5** of your *Member Handbook* for more information.



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Member (member of our plan, or plan member): A person with Medicare and Indiana PathWays for Aging who qualifies to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS) and the state.

Member Handbook and disclosure Information: This document, along with your enrollment form and any other attachments, or riders, which explain your coverage, what we must do, your rights, and what you must do as a member of our plan.

Member Services: A department in our plan responsible for answering your questions about membership, benefits, grievances, and appeals. Refer to **Chapter 2** of your *Member Handbook* for more information about Member Services.

Network pharmacy: A pharmacy (drug store) that agreed to fill prescriptions for our plan members. We call them “network pharmacies” because they agreed to work with our plan. In most cases, we cover your prescriptions only when filled at one of our network pharmacies.

Network provider: “Provider” is the general term we use for doctors, nurses, and other people who give you services and care. The term also includes hospitals, home health agencies, clinics, and other places that give you health care services, medical equipment, and long-term services and supports.

- They are licensed or certified by Medicare and by the state to provide health care services.
- We call them “network providers” when they agree to work with our health plan, accept our payment, and do not charge members an extra amount.
- While you’re a member of our plan, you must use network providers to get covered services. Network providers are also called “plan providers”.

Nursing home or facility: A facility that provides care for people who can’t get their care at home but don’t need to be in the hospital.

Ombudsman: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson’s services are free. You can find more information in **Chapters 2 and 9** of your *Member Handbook*.

Organization determination: Our plan makes an organization determination when we, or one of our providers, decide about whether services are covered or how much you pay for covered services. Organization determinations are called “coverage decisions”. **Chapter 9** of your *Member Handbook* explains coverage decisions.

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’s also called a reference product.

Original Medicare (traditional Medicare or fee-for-service Medicare): The government offers Original Medicare. Under Original Medicare, services are covered by paying doctors, hospitals, and other health care providers amounts that Congress determines.



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- You can use any doctor, hospital, or other health care provider that accepts Medicare. Original Medicare has two parts: Medicare Part A (hospital insurance) and Medicare Part B (medical insurance).
- Original Medicare is available everywhere in the United States.
- If you don't want to be in our plan, you can choose Original Medicare.

Out-of-network pharmacy: A pharmacy that has not agreed to work with our plan to coordinate or provide covered drugs to members of our plan. Our plan doesn't cover most drugs you get from out-of-network pharmacies unless certain conditions apply.

Out-of-network provider or Out-of-network facility: A provider or facility that is not employed, owned, or operated by our plan and is not under contract to provide covered services to members of our plan.

Chapter 3 of your *Member Handbook* explains out-of-network providers or facilities.

Out-of-pocket costs: The cost-sharing requirement for members to pay for part of the services or drugs they get is also called the "out-of-pocket" cost requirement. Refer to the definition for "cost-sharing" above.

Over-the-counter (OTC) drugs: Over-the-counter drugs are drugs or medicines that a person can buy without a prescription from a health care professional.

Part A: Refer to "Medicare Part A."

Part B: Refer to "Medicare Part B."

Part C: Refer to "Medicare Part C."

Part D: Refer to "Medicare Part D."

Part D drugs: Refer to "Medicare Part D drugs."

Personal health information (also called Protected health information) (PHI): Information about you and your health, such as your name, address, social security number, physician visits, and medical history. Refer to our Notice of Privacy Practices for more information about how we protect, use, and disclose your PHI, as well as your rights with respect to your PHI.

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 medical provider (PMP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary medical provider before you use any other health care provider.



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- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary medical providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of your *Member Handbook*.

Our plan covers some drugs only if you get PA from us.

- Covered drugs that need our plan's PA are marked in the *List of Covered Drugs*.

Program for All-Inclusive Care for the Elderly (PACE): A program that covers Medicare and Medicaid benefits together for people age 55 and over who need a higher level of care to live at home.

Prosthetics and orthotics: Medical devices ordered by your doctor or other health care provider that include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality improvement organization (QIO): A group of doctors and other health care experts who help improve the quality of care for people with Medicare. The federal government pays the QIO to check and improve the care given to patients. Refer to **Chapter 2** of your *Member Handbook* for information about the QIO.

Quantity limits: A limit on the amount of a drug you can have. We may limit the amount of the drug that we cover per prescription.

Real Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific covered drugs and benefit information. This includes cost sharing amounts, alternative drugs that may be used for the same health condition as a given drug, and coverage restrictions (prior authorization, step therapy, quantity limits) that apply to alternative drugs.

Referral: A referral is your primary medical provider's (PMP's) or our approval to use a provider other than your PMP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of this *Member Handbook*.

Rehabilitation services: Treatment you get to help you recover from an illness, accident, or major operation. These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy. Refer to **Chapter 4** of this *Member Handbook* to learn more about rehabilitation services.



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Sensitive services: Services related to mental or behavioral health, sexual and reproductive health, family planning, sexually transmitted infections (STIs), HIV/AIDS, sexual assault and abortions, substance use disorder, gender affirming care, and intimate partner violence.

Service area: A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's generally the area where you can get routine (non-emergency) services. Only people who live in our service area can enroll in our plan.

Share of cost: The portion of your health care costs that you may have to pay each month before your benefits become effective. The amount of your share of cost varies depending on your income and resources.

Skilled nursing facility (SNF): A nursing facility with the staff and equipment to give skilled nursing care and, in most cases, skilled rehabilitative services and other related health services.

Skilled nursing facility (SNF) care: Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous (IV) injections that a registered nurse or a doctor can give.

Specialist: A doctor who provides health care for a specific disease or part of the body.

Specialized pharmacy: Refer to **Chapter 5** of your *Member Handbook* to learn more about specialized pharmacies.

State hearing: If your doctor or other provider asks for a Medicaid service that we won't approve, or we won't continue to pay for a Medicaid service you already have, you can ask for a State hearing. If the State hearing is decided in your favor, we must give you the service you asked for.

Step therapy: A coverage rule that requires you to try another drug before we cover the drug you ask for.

Supplemental Security Income (SSI): A monthly benefit Social Security pays to people with limited incomes and resources who are disabled, blind, or age 65 and over. SSI benefits are not the same as Social Security benefits.

Urgently needed care: Care you get for a sudden illness, injury, or condition that is not an emergency but needs care right away. You can get urgently needed care from out-of-network providers when network providers are unavailable or you cannot get to them.



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Anthem I PathWays Dual Care Advantage (HMO D-SNP) Member Services

CALL	1-833-412-4405 Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 Calls to this number are free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
WRITE	Anthem Blue Cross and Blue Shield P.O. Box 105187 Atlanta GA 30348-5187
WEBSITE	www.anthem.com

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