



Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) Member Handbook

January 1 - December 31, 2027

Your Health and Drug Coverage under Anthem I MyCare Ohio Full Dual 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 MyCare Ohio Full Dual Advantage (HMO D-SNP).

This document is available for free in Spanish.

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

- You can get this document for free in other formats, such as large print, braille, and/or audio by calling Member Services at 1-833-727-2169 (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/oh/mycare.

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If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) Member Services at 1-833-727-2169 (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/oh/mycare.

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

English – ATTENTION: Language assistance, interpretation services, and auxiliary aids and services are available upon request at no cost to you. Services available include, but are not limited to: oral translation, written translation, and auxiliary aids. You can request these services and/or auxiliary aids by calling **1-833-727-2169**. Individuals with a hearing impairment may call TTY: **711**. Hours of operation are 8 a.m. to 8 p.m. local time, 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.

Español (Spanish) – ATENCIÓN: La asistencia en otros idiomas, los servicios de interpretación y las ayudas y servicios auxiliares están disponibles sin costo para usted si los solicita. Los servicios disponibles incluyen, entre otros, los siguientes: traducción oral, traducción escrita y ayudas auxiliares. Puede solicitar estos servicios y/o ayudas auxiliares llamando al **1-833-727-2169**. Las personas con discapacidad auditiva pueden llamar al TTY: **711**. El horario de atención es de 8 a.m. a 8 p.m., hora local, los siete días de la semana (excepto el Día de Acción de Gracias y Navidad) desde el 1.º de octubre hasta el 31 de marzo, y de lunes a viernes (excepto los días feriados) desde el 1.º de abril hasta el 30 de septiembre.

አማርኛ (Amharic) – ያስተውሉ:- የቋንቋ እዛዛ፣ የትርጉም አገልግሎቶች እንዲሁም አጋዥ መሣሪያዎችና አገልግሎቶች በተጠየቀ ጊዜ ለእርስዎ ያለ ምንም ክፍያ ይቀርባሉ። የሚገኙ አገልግሎቶች የሚከተሉትን ያካትታሉ፡ ነገር ግን በነዚህ ብቻ አይወሰኑም፡- የቃል ትርጉም፣ የጽሑፍ ትርጉም እና አጋዥ መሣሪያዎች። ወደ **1-833-727-2169** በመደወል እነዚህን አገልግሎቶች እና/ወይም አጋዥ መሣሪያዎች መጠየቅ ይችላሉ። የመስማት ችግር ያለባቸው ግለሰቦች ወደ TTY፡- **711** መደወል ይችላሉ። የስራ ሰዓቶች ከ 8 a.m. እስከ 8 p.m. የአካባቢ ሰዓት አቆጣጠር፣ በሳምንት ሰዓት ቀናት (ከምስጋና እና (Thanksgiving) የገና በዓላት በስተቀር) ከአክቶበር 1 እስከ ማርች 31 እና ከሰኞ እስከ አርብ (ከበዓላት በስተቀር) ከኤፕሪል 1 እስከ ሴፕቴምበር 30 ናቸው።

العربية (Arabic) – تنبيه: تتوفر المساعدة اللغوية، وخدمات الترجمة الفورية، والوسائل والخدمات المساعدة، عند الطلب دون أي تكلفة عليك. وتشمل الخدمات المتاحة على سبيل المثال لا الحصر: الترجمة الشفوية والترجمة التحريرية والوسائل المساعدة. يمكنك طلب هذه الخدمات و/أو الوسائل المساعدة بالاتصال على **1-833-727-2169**. يمكن للأفراد الذين يعانون من ضعف السمع الاتصال بـ TTY: **711**. ساعات العمل من الساعة 8 صباحًا حتى الساعة 8 مساءً، حسب التوقيت المحلي، على مدار الأسبوع (ما عدا أيام عيد الشكر وعيد الميلاد) بدايةً من 1 أكتوبر حتى 31 مارس، ومن الاثنين حتى الجمعة (ما عدا أيام الإجازات) من 1 أبريل حتى 30 سبتمبر.

简体中文 (Chinese Simplified) – 注意：我们可应要求免费为您提供语言协助、口译服务以及辅助工具和服务。提供的服务包括但不限于：口译、笔译和辅助工具。您可以致电 **1-833-727-2169** 申请这些服务和/或辅助工具。听障人士可以致电 TTY: **711**。工作时间为当地时间上午 8 点至晚上 8 点，从 10 月 1 日至 3 月 31 日的每周七天（感恩节及圣诞节除外），以及从 4 月 1 日至 9 月 30 日的周一至周五（假期除外）。

繁體中文 (Chinese Traditional) – 注意：我們可應要求免費為您提供語言協助、口譯服務以及輔助工具和服务。提供的服務包括但不限於：口譯、筆譯和輔助工具。您可以致電 **1-833-727-2169** 申請這些服務和/或輔助工具。聽障人士可以致電 TTY: **711**。工作時間為當地時間上午 8 點至晚上 8 點，從 10 月 1 日至 3 月 31 日的每週七天（感恩節及耶誕節除外），以及從 4 月 1 日至 9 月 30 日的週一至週五（假期除外）。

دري (Dari) – توجه: کمک زبانی، خدمات ترجمه و کمک ها و خدمات جانبی بنا به درخواست و بدون مصرف برای شما در دسترس است. خدمات موجود شامل، اما نه محدود به موارد زیر است: ترجمه شفاهی، ترجمه مکتوب و کمک های جانبی. شما می توانید این خدمات و/یا کمک های جانبی را با تماس گرفتن درخواست کنید **1-833-727-2169**. افراد دارای اختلال شنوایی می توانند با TTY تماس بگیرند: **711**. ساعات کاری از 8 صبح تا 8 بجه شام به وقت محلی، هفت روز در هفته (به جز روز شکرگزاری و کریسمس) از 1 اکتوبر تا 31 مارچ و از دوشنبه تا جمعه (به جز ایام رخصتی) از 1 اپریل تا 30 سپتامبر می باشد.

Français (French) – ATTENTION : une assistance linguistique, des services d'interprétation ainsi que des aides et services auxiliaires sont disponibles gratuitement sur demande. Les services disponibles comprennent notamment, sans s'y limiter : traduction orale, traduction écrite et aides auxiliaires. Vous pouvez demander ces services et/ou ces aides auxiliaires en appelant le **1-833-727-2169**. Les personnes malentendantes ou sourdes peuvent utiliser le service TTY au : **711**. Les heures d'ouverture sont de 8 a.m. à 8 p.m., heure locale, sept jours sur sept (sauf Thanksgiving et Noël) du 1er octobre au 31 mars, et du lundi au vendredi (sauf jours fériés) du 1er avril au 30 septembre.

Deutsch (German) – ACHTUNG: Auf Anfrage stehen Ihnen Sprachunterstützung, Dolmetscherdienste sowie Zusatzhilfen und Dienstleistungen kostenlos zur Verfügung. Zu den angebotenen Dienstleistungen gehören unter anderem die folgenden: Mündliche und schriftliche Übersetzungen sowie Zusatzhilfen. Sie können diese Dienstleistungen und/oder Zusatzhilfen unter der Telefonnummer **1-833-727-2169** anfordern. Personen mit einer Hörbeeinträchtigung können die TTY-Nummer anrufen: **711**. Die Geschäftszeiten sind 8 Uhr bis 20 Uhr lokaler Zeit an sieben Tagen in der Woche (außer Thanksgiving und Weihnachten) vom 1. Oktober bis zum 31. März, und Montag bis Freitag (außer an Feiertagen) vom 1. April bis zum 30. September.

ગુજરાતી (Gujarati) – ધ્યાન આપો: ભાષાકીય સહાય, દુભાષિયાની સેવાઓ અને સહાયક સાધનો તેમજ સેવાઓ, વિનંતી કરવા પર તમારા માટે વિના મૂલ્યે ઉપલબ્ધ છે. ઉપલબ્ધ સેવાઓમાં નીચેનાનો સમાવેશ થાય છે, પરંતુ તે તેના પૂરતી મર્યાદિત નથી: મૌખિક અનુવાદ, લેખિત અનુવાદ અને સહાયક સાધનો. તમે **1-833-727-2169** પર કોલ કરીને આ સેવાઓ અને/અથવા સહાયક સાધનો માટે વિનંતી કરી શકો છો. શ્રવણ ક્ષતિ ધરાવતી વ્યક્તિઓ TTY પર કોલ કરી શકે છે: **711**. કામકાજના કલાકો સ્થાનિક સમય મુજબ સવારે 8 વાગ્યાથી સાંજના 8 વાગ્યા સુધી, ઓક્ટોબર 1 થી માર્ચ 31 સુધી અઠવાડિયાના સાતેય દિવસ (થેંક્સગિવિંગ અને ક્રિસમસ સિવાય) અને સોમવારથી શુક્રવાર (રજાઓ સિવાય) એપ્રિલ 1 થી સપ્ટેમ્બર 30 સુધી છે.

Kreyòl Ayisyen (Haitian Creole) – ATANSYON: Asistans lang, sèvis entèpretasyon, ak lòt sèvis sipò disponib gratis sou demann. Sèvis ki disponib yo gen ladan l bagay tankou: tradiksyon oral, tradiksyon ekri, ak lòt sèvis sipò. Ou ka mande sèvis ki annapre yo ak/oswa sèvis sipò lè w rele **1-833-727-2169**. Moun ki gen pwoblèm pou tande oswa ki soud ka itilize sèvis TTY nan **711**. Orè nou travay yo se 8 a.m. rive 8 p.m. lè lokal, sèt jou sou sèt (eksepte Thanksgiving ak Nwèl) soti 1ye oktòb rive 31 mas, epi lendi rive vandredi (eksepte jou ferye) soti 1ye avril rive 30 septanm.

日本語 (Japanese) – 注意：言語支援、通訳サービス、その他の補助器具・サービスは、ご要望に応じて無料でご利用いただけます。利用可能なサービスには、以下が含まれますが、これらに限定されません。口頭翻訳、文書翻訳、および補助器具。これらのサービスや補助器具をご希望の場合は、**1-833-727-2169**までお電話でお申し込みください。聴覚障害のある方は、TTYをご利用いただけます。**711**。営業時間は、10月1日から3月31日までは現地時間午前8時から午後8時まで週7日（感謝祭とクリスマスを除く）、および4月1日から9月30日まで（祝日を除く）は月曜日から金曜日までです。

Ikinyarwanda (Kinyarwanda) – ICYITONDERWA: Serivisi z'ubufasha bw'ururimi, serivisi z'ubusemuzi, n'ibikoresho bifasha abafite ibumuga bwo kutumva n'izindi, biraboneka iyo ubisabye kandi ku buntu. Serivisi ziboneka zirimo, ariko ntizigarukira gusa kuri izi zikurikira: ubusemuzi mvugo, ubusemuzi bw'inyandiko, ndetse n'ibikoresho byunganira. Ushobora gusaba izi serivisi kandi/cyangwa ibikoresho byunganira uhamagara kuri **1-833-727-2169**. Abafite ibumuga bwo kutumva bashobora guhamagara kuri TTY: **711**. Amasaha y'akazi ahera saa 8:00 za mugitondo kugera saa 8:00 z'umugoroba ku isaha isanzwe, iminsi irindwi mu cy'umweru (ukuyemo iminsi yo gushimira Imana na Noheli) guhera tariki ya 1 Ukwakira kugeza tariki ya 31 Werurwe, ku wa Mbere kugeza ku wa Gatanu (ukuyemo iminsi y'ikiruhuko) guhera tariki ya 1 Mata kugeza tariki ya 30 Nzeri.

한국어 (Korean) – 주의: 언어 지원, 통역 서비스, 추가 보조 및 서비스가 요청 시 무료로 제공됩니다. 이용 가능한 서비스에는 구두 번역, 서면 번역 및 추가 보조가 포함됩니다(이에만 국한되지 않음). **1-833-727-2169** 번으로 전화하여 이러한 서비스 및/또는 추가보조를 요청하실 수 있습니다. 청각 장애가 있는 분은 TTY: **711**번으로 전화하실 수 있습니다. 운영 시간은 10월 1일부터 3월 31일까지는 추수감사절과 크리스마스를 제외하고 주 7일 현지 시간 오전 8시-오후 8시, 4월 1일부터 9월 30일까지는 휴일을 제외하고 월요일-금요일, 같은 시간입니다.

मराठी (Marathi) – लक्ष द्या: भाषा सहाय्य, दुभाषी सेवा आणि सहाय्यक उपकरणे व सेवा विनंतीनुसार तुम्हाला विनाशुल्क उपलब्ध आहेत. उपलब्ध सेवांमध्ये खालील सेवांचा समावेश आहे, परंतु त्या इतक्यापुरत्या मर्यादित नाहीत: मौखिक अनुवाद, लिखित अनुवाद आणि सहाय्यक उपकरणे. तुम्ही **1-833-727-2169** वर कॉल करून या सेवा आणि/किंवा सहाय्यक उपकरणांची विनंती करू शकता. श्रवणदोष असलेल्या व्यक्ती TTY वर कॉल करू शकतात: **711**. कामकाजाची वेळ स्थानिक वेळेनुसार सकाळी 8 ते रात्री 8 पर्यंत, 1 ऑक्टोबर ते 31 मार्च पर्यंत आठवड्याचे सातही दिवस (थॅक्सगिव्हिंग आणि ख्रिसमस वगळून) आणि 1 एप्रिल ते 30 सप्टेंबर पर्यंत सोमवार ते शुक्रवार (सुट्ट्या वगळून) आहे.

नेपाली (Nepali) – ध्यान दिनुहोस्: अनुरोध भएमा तपाईंको लागि भाषा सहायता, दोभासे सेवाहरू र अन्य सहायता तथा सेवाहरू निःशुल्क उपलब्ध छन्। उपलब्ध सेवाहरूमा निम्न लगायतका छन्: मौखिक अनुवाद, लिखित अनुवाद र सहायक सामग्रीहरू। तपाईंले यी सेवाहरू र/वा सहायक सहायताहरू अनुरोध गर्न सक्नुहुन्छ: **1-833-727-2169**। श्रवणशक्तिमा समस्या भएका व्यक्तिहरूले TTY मा कल गर्न सक्छन्: **711**। कार्य सञ्चालन गरिने समय स्थानीय समयअनुसार बिहान 8 बजेदेखि साँझ 8 बजेसम्म हप्ताको सातै दिन (थ्याङ्क्सगिभिङ र क्रिसमसबाहेक) अक्टोबर 1 देखि मार्च 31 सम्म र सोमवारदेखि शुक्रवार (बिदाबाहेक) अप्रिल 1 देखि सेप्टेम्बर 30 सम्म हो।

پښتو (Pashto) – پاملرنه: د ژبې مرسته، د ژباړې خدمتونه، او مرستندويه مرستې او خدمات ستاسو د غوښتنې په صورت کې وړيا شتون لري. شتون لرونکي خدمات په لاندې مواردو پورې محدود نه دي، بلکې نور خدمات هم پکې شامل دي: شفاهي ژباړه، ليکلي ژباړه، او مرستندويه وسايل. تاسو کولی شئ د دې خدماتو او/يا مرستندويه وسايلو غوښتنه د زنگ و هلو له لارې وکړئ **1-833-727-2169**. هغه کسان چې د اورېدو ستونزه لري، کولی شي د TTY له لارې اړيکه ونيسي: **711**. د فعاليت ساعتونه د محلي وخت له مخې له سهار 8 بجو څخه د ماښام تر 8 بجو پورې، اووه ورځې په اونۍ کې (پرته د منځنۍ کولو او کرسمس ورځې) د اکتوبر له 1 نېټې څخه تر مارچ 31 پورې، او له اپريل 1 څخه تر سپټمبر 30 پورې د دوښنبې څخه تر جمعې پورې (پرته له رخصتيو) څخه دی.

Deutsch (Pennsylvania Dutch) – WICH DICH: Wann du Hilf brauchst fer communicat-e, kenne mer dich helfe in en latt differnti Wege, unni as es dich ennich eppes koschde zellt. Samm (un net all) vun die Services as mir provid-e kenne sin: Translations as geschwetzt odder gschriwwe sin un differnti annri Tools fer Leit helfe Sache verschteh un communicat-e. Du kannst froge fer ennich eppes wie des bei calle **1-833-727-2169**. Leit as Druwwel hen fer heere kenne TTY calle: **711**. Mir kenne dei Call nemme 8 Uhr meigeds bis 8 Uhr oweds local Zeit, siwwe Daag die Woch (ausgunme Thanksgiving un Grischdaag) vun October 1 deich March 31, un muundaags bis freidaags (ausgunme Feierdaage) vun April 1 deich September 30.

Русский (Russian) – ВНИМАНИЕ: лингвистическую помощь, устный перевод, а также вспомогательные средства и поддержку предоставляют по запросу бесплатно. Покрывают, в частности, такие услуги: устный или письменный переводы и обеспечение вспомогательными средствами. Вы можете запросить их, позвонив по номеру телефона **1-833-727-2169**. Лица с нарушениями слуха могут обращаться по линии ТТТ: **711**. Часы работы: с 8 a.m. до 8 p.m. без выходных (кроме Дня благодарения и Рождества) с 1 октября по 31 марта и с понедельника по пятницу (кроме праздничных дней) с 1 апреля по 30 сентября.

Soomaali (Somali) – FIIRO GAAR AH: Caawimaad luuqadeed, adeegyada turjumaada, iyo qalabka gargaarka maqalka iyo adeegyo ayaa la helo marka la codsado kuwaas oo qarash la'aan kugu ah. Adeegyada la heli karo waxaa ka mid ah, laakiin kuma jiraan: turjumaada afka ah, turjumaada qoraalka ah, iyo qalabka gargaarka maqalka. Waxaad adeegyadaan ku codsan kartaa iyo/ama qalabka gargaarka maqalka adiga oo wacaya **1-833-727-2169**. Shaqsiyaadka qaba naafanimada maqalka waxay wici karaan TTY: **711**. Saacadaha shaqada waa 8 a.m. illaa 8 p.m. saacadaha maxaliga, todoba maalmood isbuucii (marka laga reebo fasaxa Mahadnaqa iyo Kirismaska) laga bilaabo Oktoobar 1 illaa Maarso 31, iyo Isniin illaa Jimcaha (marka laga reebo fasaxyada) laga bilaabo Abriil 1 illaa Sebteembar 30.

Kiswahili (Swahili) – ANGALIZO: Usaidizi wa lugha, huduma za ukalimani, pamoja na vifaa na huduma saidizi vinapatikana kwa ombi bila malipo yoyote kwako. Huduma zinazopatikana ni pamoja na, lakini hazikomei kwenye zifuatazo: ukalimani wa papo kwa papo, tafsiri ya maandishi, na vifaa saidizi. Unaweza kuomba huduma hizi na/au vifaa saidizi kwa kupiga simu kwa **1-833-727-2169**. Watu wenye ulemavu wa kusikia wanaweza kupiga simu kupitia TTY: **711**. Saa za kazi ni saa 8 asubuhi hadi saa 8 jioni kwa saa za eneo husika, siku saba kwa wiki (isipokuwa Sikukuu ya Shukrani na Krismasi) kuanzia Oktoba 1 hadi Machi 31, na Jumatatu hadi Ijumaa (isipokuwa sikukuu za umma) kuanzia Aprili 1 hadi Septemba 30.

తెలుగు (Telugu) – గమనిక: భాషా సహాయం, అనువాద సేవలు, మరియు సహాయక పరికరాలు మరియు సేవలు మీ అభ్యర్థన మేరకు మీకు ఎటువంటి ఖర్చు లేకుండా అందుబాటులో ఉంటాయి. అందుబాటులో ఉన్న సేవలలో ఇవి ఉన్నాయి, కానీ వీటికే పరిమితం కావు: మౌఖిక అనువాదం, లిఖిత అనువాదం మరియు సహాయక పరికరాలు. మీరు **1-833-727-2169** కు కాల్ చేయడం ద్వారా ఈ సేవలను మరియు/లేదా సహాయక పరికరాలను అభ్యర్థించవచ్చు. వినికిడి లోపం ఉన్న వ్యక్తులు TTYకి కాల్ చేయవచ్చు: **711**. పని వేళలు అక్టోబర్ 1 నుండి మార్చి 31 వరకు వారానికి ఏడు రోజులు (థాంక్స్ గివింగ్, క్రిస్మస్ మినహా), అలాగే ఏప్రిల్ 1 నుండి సెప్టెంబర్ 30 వరకు సోమవారం నుండి శుక్రవారం వరకు (సెలవులు మినహా) ఉదయం 8 గంటల నుండి రాత్రి 8 గంటల వరకు.

Українська (Ukrainian) – УВАГА: лінгвістичну допомогу, усний переклад і допоміжні засоби й підтримку надають за запитом безкоштовно. Зокрема, покривають такі послуги: усний і письмовий переклади та забезпечення допоміжними засобами. Ви можете замовити їх, зателефонувавши за номером **1-833-727-2169**. Особи з порушеннями слуху можуть звертатися за лінією ТТТ: **711**. Години роботи: з 8 a.m. до 8 p.m. без вихідних (крім Дня подяки й Різдва) з 1 жовтня по 31 березня, з понеділка по п'ятницю (крім святкових днів) з 1 квітня по 30 вересня.

Tiếng Việt (Vietnamese) – CHÚ Ý: Hỗ trợ ngôn ngữ, dịch vụ thông dịch, cũng như các phương tiện hỗ trợ và dịch vụ phụ trợ được cung cấp theo yêu cầu và không tính phí cho quý vị. Các dịch vụ hiện có bao gồm, nhưng không chỉ gồm: dịch miêng, dịch thuật văn bản và các phương tiện hỗ trợ phụ trợ. Quý vị có thể yêu cầu các dịch vụ này và/hoặc các phương tiện hỗ trợ phụ trợ bằng cách gọi **1-833-727-2169**. Những người bị khiếm thính có thể gọi TTY: **711**. Giờ làm việc là từ 8 giờ sáng đến 8 giờ tối theo giờ địa phương, bảy ngày một tuần (trừ Lễ Tạ Ơn và Giáng Sinh), từ ngày 1 Tháng Mười đến 31 Tháng Ba, và Thứ Hai đến Thứ Sáu (trừ các ngày nghỉ lễ), từ ngày 1 Tháng Tư đến 30 Tháng Chín.

יידיש (Yiddish) – אכטונג: שפראך-הילף, אינטערפרעטאציע-דינסטן, און צוגעהעריקע הילפס-מיטלען און סערוויסן זײַנען פֿאַראַן לויט אייער בקשה, אָן קיין קאָסטן פֿאַר אײַך. די פֿאַראַנענע סערוויסן נעמען אַרײַן, אָבער זײַנען נישט באַגרענעצט צו: מינדלעכע איבערזעצונג, שריפטלעכע איבערזעצונג, און צוגעהעריקע הילפס-מיטלען. איר קענט פארלאנגען די סערוויסן און/אָדער צוגעהעריקע הילפס-מיטלען דורך רופן **1-833-727-2169**. מענטשן מיט אַ געהער־באַגרענעצונג קענען רופן TTY: **711**. די אַרבעטס-שעהן זענען 8 a.m. ביז 8 p.m. לאקאלע צייט, זיבן טעג אַ וואָך (אחוץ טהאַנקסגיווינג און ניטל) פון 1 אקטאבער ביז 31 מערץ, און מאנטיק ביז פרייטאג (חוץ פֿיערטעג) פון 1 אפריל ביז 30 סעפטעמבער.

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If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Disclaimers

- Anthem Blue Cross and Blue Shield is an HMO D-SNP plan with a Medicare contract and a contract with the Ohio 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 Community Insurance Company. 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 MyCare Ohio Full Dual 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 1-833-727-2169 (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 anytime. You'll get a notice about any changes that may affect you at least 30 days in advance.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Chapter 1: Getting started as a member

Introduction

This chapter includes information about Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP), a health plan that covers all of your Medicare and Medicaid services, and your membership in it. It also tells you what to expect and what other information you'll get from us. 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

A. Welcome to our plan

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

B. Information about Medicare and Medicaid

B1. Medicare

Medicare is the federal health insurance program for:

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

B2. Medicaid

Medicaid is the name of the Ohio Medicaid program. Medicaid is run by the state and is paid for by the state and the federal government. Medicaid program 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,
- 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 Ohio approved our plan. You can get Medicare and Medicaid services through our plan as long as:

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

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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

C. Advantages of our plan

You'll now get all your covered Medicare and Medicaid 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 and work better for you. Some of the advantages include:

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

D. Our plan's service area

Our service area includes these counties in Ohio: Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware, Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood, and Wyandot.

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 this *Member Handbook* for more information about the effects of moving out of our service area.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 aren't considered living in the service area even if they're 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, **and**
- are currently eligible for Medicaid, **and**
- aren't enrolled in the Program of All-Inclusive Care for the Elderly (PACE), **and**
- don't have other third-party creditable coverage, **and**
- aren't inmates of public institutions, **and**
- aren't an individual with intellectual disabilities who meets certain criteria and receives home and community-based services (HCBS) waiver services, **and**
- aren't an individual with intellectual disabilities who receives services through an intermediate care facility for individuals with intellectual disabilities (ICF-ID), **and**
- are 21 years of age, or older.
- If you lose your Ohio Medicaid eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP). When your Ohio Medicaid coverage ends, we won't pay for your Ohio Medicaid 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 Ohio Medicaid eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

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

We'll assist you to regain your Ohio Medicaid eligibility. If your Ohio Medicaid 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 Ohio Medicaid 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 Ohio Medicaid within six months we'll disenroll you from Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP). If you regain Ohio Medicaid eligibility after being disenrolled, you'll need to contact us to reenroll in the plan.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

If you lose eligibility but can be expected to regain it within 6 months then you're still eligible for our plan.

Call Member Services for more information.

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

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

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

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, waiver service coordinator (if the member is enrolled in the MyCare waiver), social workers, mental health and substance use disorder licensed independent professionals, gerontologists, housing specialists, transportation specialists, and community health workers.

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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 MyCare Ohio Full Dual 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Medicaid 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 

Anthem | MyCare OH Full Dual Advantage
is a managed care plan that contracts with both Medicare and OH Medicaid

Member Name:
Member ID:
MMIS Number:

PCP:
PCP Phone:

Dual eligible members pay \$0 for plan covered medical services.

CMS H2628-001-000

MedicareRx
Prescription Drug Coverage

RxBIN: <020115>
RxPCN: <IS>
RxGRP: <WM2A>
RxD: <MemberID>

Member: Present this ID card before you receive Medicare or Medicaid services or supplies. Please 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.

Provider: Please check the ODM provider portal for member eligibility. Submit claims to the Fiscal Intermediary through EDI via ODM Trading Partners; or through the Anthem Availity claims portal. Outside the plans service area, benefits may be limited to Emergency care.

Member Service:	<1-833-727-2169>	Dental Member Service:	<1-888-700-0992>
TTY/TDD Line:	<711>	24/7 NurseLine:	<1-855-658-9249>
Member Pharmacy Svc:	<1-833-485-9055>	Care Coordination:	<1-833-727-2169>
Help for Pharmacists:	<1-833-377-4266>	BH Crisis Line:	<1-833-727-2043>
Provider Service:	<1-800-676-2883>	livehelp@anthem.com	

Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company, Independent licensee of the Blue Cross and Blue Shield Association.

<anthem.com>

Possession of this card does not guarantee eligibility for benefits.
Submit paper claims to:
Medical: <P.O. Box 105187, Atlanta, GA 30348>
Pharmacy: <Claims Dept-Part D Services, P.O. Box 52077, Phoenix, AZ 85072>



Department of Medicaid

Next Generation of MyCare Ohio

Issue Date: <MMDDYYYY>

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 MyCare 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Behavioral health services including but not limited to medication assisted treatment (MAT), substance use disorders LTSS (SUD), mental health and other community behavioral health providers; **and**
 - o long-term services and supports (LTSS) providers other than nursing facility including adult day providers, assisted living facilities, home health agencies, home delivered meals, home health aide, homemaker, home modification, personal care, private duty and waiver nursing services; **and**
 - o durable medical equipment (DME) suppliers, transportation, vision, dental and others who provide goods and services that you get through Medicare or Medicaid.

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

Definition of network pharmacies

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

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

List of Durable Medical Equipment (DME)



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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've been removed and replaced as described in **Chapter 5, Section B**. Medicare approved the Anthem I MyCare Ohio Full Dual 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:



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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**
- 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.

You may also contact your local County Department of Job and Family Services if you have questions or need to report changes to your address, income, or other insurance. To find your local county agency, visit www.jfs.ohio.gov/County/County_Directory.stm.

You can also visit the Ohio Department of Medicaid online at www.medicaid.ohio.gov.

To keep your Medicaid information up to date online, visit the Self Service Portal Home Page at www.ssp.benefits.ohio.gov/apsspssp/ssp.portal. You can also update your contact information at www.medicaid.ohio.gov/home/update-contact-info/select-county-dropdown.

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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

A. Member Services

CALL	1-833-727-2169. 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/oh/mycare

Contact Member Services to get help with:

- questions about the plan
- questions about claims or billing
- coverage decisions about your health care
 - o 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.
 - o Call us if you have questions about a coverage decision about your health care.
 - o To learn more about coverage decisions, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your health care
 - o 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.
 - o 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- complaints about your health care
 - You can make a complaint about us or any provider (including a non-network or network provider). A network provider is a provider who works with our plan. You can also make a complaint to us or to the Quality Improvement Organization (QIO) about the quality of the care you received (refer to **Section D**).
 - You can call us and explain your complaint at 1-833-727-2169.
 - If your complaint is about a coverage decision about your health care, you can make an appeal (refer to the section above **Section F**).
 - 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.
 - You can send a complaint about Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) directly to the Ohio Department of Medicaid Call 1-800-324-8680. This call is free.
 - You can send a complaint about Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) to the MyCare Ohio Ombudsman. Call 1-800-282-1206. This call is free.
 - To learn more about making a complaint about your health care, refer to **Chapter 9** of this *Member Handbook*.
- coverage decisions about your drugs
 - A coverage decision about your drugs is a decision about:
 - your benefits and covered drugs or
 - the amount we pay for your drugs.
 - This applies to your Medicare Part D drugs and Medicaid drugs including over-the-counter drugs.
 - For more on coverage decisions about your prescription drugs, refer to **Chapter 9** of this *Member Handbook*.
- appeals about your drugs
 - An appeal is a way to ask us to change a coverage decision.
 - For more on making an appeal about your prescription drugs, refer to **Chapter 9** of this *Member Handbook*.
- complaints about your drugs



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 **Section F**.)
- 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

At Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP), you will have the support of a care coordinator to assist you before, during and after a health event.

When you become an Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) member, you will be assigned to a care coordinator.

- A care coordinator is 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.
- A care coordinator will reach out to you to make sure you have what you need. If you enter the hospital, a care coordinator can help arrange for services that make it possible to recover at home.
- If you feel that you could use the help of a care coordinator, you can contact Member Services and ask to speak to a care coordinator.
- If you are not comfortable with your care coordinator, you can call Member Services at 1-833-727-2169 (TTY: 711), Monday through Friday from 8 a.m. to 8 p.m. to find a care coordinator to meet your needs.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

CALL	1-833-727-2169. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. We have free interpreter services for people who do not speak English.
TTY	711. This call is free. 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30.
FAX	1-877-664-1504
WRITE	P.O. Box 105187 Atlanta, GA 30348-5187
WEBSITE	www.anthem.com/oh/mycare

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
- questions about identifying needs and getting access to Long Term Services and Support

C. Ohio Senior Health Insurance Information Program (OSHIIP)

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 Ohio, the SHIP is called OSHIIP.

OSHIIP 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	1-800-686-1578 Monday - Friday 7:30am - 5:00pm
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If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

TTY	711 then dial 614-644-3264
WRITE	50 W Town St Third Floor - Suite 300 Columbus, OH 43215
EMAIL	oshiipmail@insurance.ohio.gov
WEBSITE	www.insurance.ohio.gov/about-us/divisions/oshiip

Contact OSHIIP for help with:

- questions about Medicare
- OSHIIP 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**
 - o straighten out problems with your bills.

D. Quality Improvement Organization (QIO)

Our state has an organization called Quality Improvement Organization (QIO). This is a group of doctors and other health care professionals who help improve the quality of care for people with Medicare. QIO is an independent organization. It's not connected with our plan.

CALL	1-888-524-9900
TTY	711
WRITE	Commence Health Commence Health PO Box 2687 Virginia Beach, VA 23454
EMAIL	Communications@commence.ai



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

WEBSITE	https://www.commencehealthqio.cms.gov/en
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Contact 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.
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



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.
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F. Medicaid

Medicaid 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 Ohio Medicaid Hotline 1-800-324-8680 Member Services: Monday-Friday 7 a.m.- 8 p.m. and Saturday 8 a.m.-5 p.m. ET.

CALL	1-800-324-8680 Monday-Friday 7 a.m. to 8 p.m., Saturday 8 a.m. to 5 p.m. ET
TTY	TTY users should call the Ohio Relay Service at 7-1-1.
WRITE	505 South High Street Columbus, OH 43215
WEBSITE	https://medicaid.ohio.gov/home



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

G. MyCare Ohio Ombudsman

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

CALL	1-800-282-1206 Monday through Friday 8 a.m. to 5 p.m.
TTY	For TTY, use Relay Ohio: Dial 711 and use 614-466-5500 for general information.
WRITE	Ohio Department of Aging 30 E Broad St, 22nd Floor Columbus, OH 43215-3414
WEBSITE	www.aging.ohio.gov/

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."

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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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

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

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

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

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

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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right copayment amount when you get your next prescription. If you overpay your copayment, we'll pay you back either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Call Member Services at the number at the bottom of the page if you have questions.

H2. 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 Ohio Department of Health (ODH) White Part B Program.

The ODH Ryan White Part B Program promotes health and access to quality care for Ohioans living with HIV. The program offers a full spectrum of services. To be eligible for the program you must:

- have an HIV positive diagnosis,
- be an Ohio resident, **and**
- have a gross income at or below 500% of the federal poverty level.

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 contact:

Bureau of HIV, STI, and Viral Hepatitis
Ohio Department of Health
246 N High St
Columbus, OH 43215

Telephone: (614) 466-6374, (800) 777-4775
Fax: (866) 448-6337 (toll free)
E-Mail: hcs@odh.ohio.gov

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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

CALL	1-800-772-1213
	Calls to this number are free.
	Available 8 a.m. to 7 p.m., Monday through Friday.
TTY	You can use their automated telephone services to get recorded information and conduct some business 24 hours a day.
	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, it is important that you 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.
TTY	Press "1" to access the automated RRB Help Line and get recorded information 24 hours a day, including weekends and holidays.
	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.
WEBSITE	Calls to this number are <i>not</i> free.
	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're 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 this *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 this *Member Handbook*. Your covered services for prescription and over-the-counter drugs are in **Chapter 5** of this *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 *and your cost-sharing amount* 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 Medicaid. 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 care provider (PCP)** providing and overseeing your care. As a plan member, you must choose a network provider to be your PCP (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 services you get. Here are some cases when this rule doesn't apply:
 - If you need emergency or urgently needed care from an out-of-network provider (for more information, go to **Section I** in this chapter).



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- 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 as if you got it from a network provider at no cost to you. For information about getting approval to use an out-of-network provider, go to **Section D4** in this chapter.
- o If you need kidney dialysis services when you're outside our plan's service area for a short time or when your provider is temporarily unavailable or not accessible, you can get care from an out-of-network provider. The cost-sharing you pay for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan's service area and get dialysis from a provider outside the plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from an out-of-network provider, your cost-sharing for the dialysis may be higher. 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

C1. What a care coordinator is

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

A care coordinator helps patients:

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

C2. How you can contact your care coordinator

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



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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 care provider (PCP)

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

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

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

Your PCP can be:

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

Your choice of PCP

Your relationship with your PCP is important. So when you choose your PCP, try to think about the reasons below to help you. When you choose a PCP, 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 MyCare Ohio Full Dual Advantage (HMO D-SNP), you will select a PCP by using our Provider and Pharmacy Directory. PCPs 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 PCP's office. If you need help choosing a PCP, call Member Services at 1-833-727-2169 (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 select your PCP, you are also choosing the hospital(s) and specialty network(s) associated with your PCP.

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



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For help in selecting a PCP, you can also call Member Services at 1-833-727-2169 (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.

Option to change your PCP

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

To change your PCP, call Member Services at 1-833-727-2169, (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 PCP's approval. Some of these services may be home health services and durable medical equipment.

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

We'll send you a new Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) Member ID Card with your new PCP'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 PCP or specialist will need to get prior approval from us. This is called getting "prior authorization". (For more information about this, see the Medical Benefits Chart in **Chapter 4**.) When we give our decision, we base it on two things. First there are Medicare's and the state Medicaid program's rules. Second, there are generally accepted standards of medical practice. These standards are proven and accepted by those who practice and study medicine. We also need to make sure you get the most cost effective care. This means it doesn't cost more than another option that will work just as well. But we also need it to be right for you. And that you get it in the right place and the right number of times. Finally, we cannot approve a service just because it is more convenient than another option. You must get our approval before getting care from providers not in our plan unless it's for urgent care, emergency care or renal dialysis outside the service area. To find a provider in our plan, check our Find a Doctor tool online or call 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.

If we are unable to find you a qualified plan network provider, we must give you a standing service authorization for a qualified specialist for any of these conditions:

- a chronic (ongoing) condition;
- a life-threatening mental or physical illness;
- a degenerative disease or disability;
- any other condition or disease that is serious or complex enough to require treatment by a specialist

If you do not get a service authorization from us when needed, the bill may not be paid. For more information, call Member Services at the phone number printed at the bottom of this page.

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 that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we'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



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unavailable or inadequate to meet your medical needs. You **MUST** get prior approval for these services.

- 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.)

D4. Out-of-network providers

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

- We can't pay a provider who isn't eligible to participate in Medicare and/or Medicaid.
- 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.

This plan does not provide coverage for services received from out-of-network providers, except for emergency, urgently needed care and end-stage renal disease services. You are not responsible for obtaining authorization for emergency, urgently needed care or end-stage renal disease services received from out-of-network providers.

You must receive your care from a network provider (for more information about this, see Section D2 in this chapter.) In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. This means that you will have to pay the provider in full for the services furnished. Here are three exceptions:

- If you need medical care that Medicare or Medicaid requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost sharing you normally pay in-network. You should obtain authorization from the plan prior to seeking care. In this situation, we will cover these services at no cost to you. For information about getting approval to see an out-of-network doctor. For instructions on how to obtain a prior authorization contact Member Services or your health care provider.
- The plan covers emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see **Chapter 12** definitions.
- The plan covers kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area or when your provider for this service is



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temporarily unavailable or inaccessible. The cost sharing you pay the plan for dialysis can never exceed the cost sharing in Original Medicare. If you are outside the plan's service area and obtain the dialysis from a provider that is outside the plan's network, your cost sharing cannot exceed the cost sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to obtain services inside the service area from a provider outside the plan's network the cost sharing for the dialysis may be higher.

E. Long-term services and supports (LTSS)

Covered services up to limits outlined in the MyCare program include:

- Crisis Intervention for members who go through a psychiatric crisis to:
 - Reduce symptoms.
 - Help stabilize and restore a person to his or her former level of function.
- Crisis Stabilization to help a person in crisis return to his or her prior level of function.
- Prescribed Electroconvulsive Therapy to treat severe mental illness.
- Hospital-based Detoxification/Chemical Dependency. Services:
 - Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol.

* Certain limits apply as determined by MyCare.

- Inpatient Professional Services given within an inpatient setting by:
 - Psychiatrists
 - Psychologists
 - Clinical social workers
 - Therapists
 - Medical doctors or specialists
 - Certified Nurse Practitioners
- Intensive Outpatient Program for psychiatric and chemical dependency that:
 - o Meets several times a week for at least three hours of mental health or substance/alcohol abuse services.
 - o Aims to improve a person's level of function to prevent a relapse or hospital admission.



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- o Medication Assisted Treatment such as a Methadone Maintenance Program for the treatment of heroin addiction.
- o Neurotherapy — also referred to as neurofeedback or EEG biofeedback — is a process to observe the central nervous system and the brain. This allows for a better understanding of possible irregularities in the brain, and treatment can train the brain to correct the irregularities.
- o Hospital observation services.
- o Outpatient/ambulatory detox and/or rehab services:
 - Aimed to restore the mental and physical well-being of those who abuse drugs or alcohol.
- Outpatient mental health/substance abuse services include:
 - o Basic medical and therapeutic services
 - o Crisis services
 - o Review and diagnosis of care
 - o Individual, family and/or group therapy
 - o Medication management

You may receive these services from authorized physicians, psychologists, or other mental health professionals.

- Partial Hospital, Psychiatric and Chemical Dependency Treatment programs that:
 - o Are offered Monday through Friday for at least six hours each day.
 - o Are provided by a hospital in an outpatient setting.
 - o Provide a range of psychiatric and substance abuse treatment services.
 - o Offer partial hospital care as an alternative to inpatient psychiatric or substance abuse care.
- Psychosocial rehabilitation services/basic skills training to help reach or maintain a person's greatest level of function.
- Make the most of their personal strengths.
- Develop ways to cope and deal with areas of weakness.
- Build a supportive environment in which to function.
- Psychological and neuropsychological testing that is used by psychologists to test:



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- Mood
- Personality type
- Learning skills

These tests can be used to help decide a mental health diagnosis. Covered services include:

- Neuropsychological testing
- Neurobehavioral testing
- Psychological testing
- Residential treatment center (RTC) Alcohol and drug abuse to residents who do not require acute medical care
- Services include:
 - o Individual, group and family therapy
 - o Medication management
 - o Medical treatment
 - o Lab testing
 - o Room and board

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

Sometimes, dealing with the tasks of stress and daily life and/or post-traumatic experiences can lead to depression, anxiety, or other mental health challenges. It can also lead to marriage, family, and/or parenting problems. In addition, life stresses can lead to alcohol and illegal drug use. If you or a family member are having these kinds of problems, you can get help. Call Member Services at 1-833-727-2169 711. You can also get the name of a behavioral health specialist if you need one. To reach the MYCare Behavioral Health Member Crisis Line, please call 1-833-727-2043 (TTY 711). Please note this should not be used in place of 911. If you are in imminent risk, please call 911 or visit an emergency room. If you think a behavioral health specialist doesn't meet your needs, talk to your PCP. They can help you find a different kind of specialist. You do not need to see your PCP before getting behavioral health services. But, you will need to get your care from someone who is in our network.



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G. How to get self-directed care

G1. What self-directed care is

Self-directed care is a service model within Medicaid waivers in Ohio that empowers individuals to have choice and control over their long-term services and supports. It allows them to make decisions regarding the type of care they receive, how services are delivered, and the selection of caregivers. Participants in self-direction have authority over their budget-deciding how funds are spent-and employer authority-overseeing and managing their caregivers.

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

Individuals who are enrolled in the MyCare Waiver or the Ohio Home Care Waiver are eligible for self-directed services. Each waiver presents different services under the self-direction model, and these must address the individual's needs as identified in their person-centered service plan.

G3. How to get help in employing personal care providers (if applicable)

To get help in employing personal care providers, individuals should work closely with their care manager, who will guide them through the self-direction process. This includes providing information on finding caregivers, understanding roles and responsibilities as an employer, and handling logistics such as conducting reviews. Additionally, for more information or assistance, individuals can contact selfdirection@medicaid.ohio.gov, or their care manager or waiver service coordinator if they're enrolled in relevant waivers like the Ohio Home Care Waiver or MyCare Waiver.

Services are outlined in the person-centered service plan. The following services may be self-directed:

- **Personal Care Aide**-Trained aides assist with daily living activities (ADLs) and instrumental activities of daily living (IADLs), such as hygiene, mobility, home care, and accessing the community.
- **Choices Home Care Attendant**-Similar to a personal care aide with the addition of assisting with money management, home maintenance, and chores. It can also provide transportation services with prior approval.
- **Home Care Attendant**-Provides assistance with skilled nursing services such as medication administration and other ADLs. Requires RN consultation and approval from a primary care provider.
- **Waiver Nursing**-Provides skilled nursing tasks, including personal care support, requiring a licensed RN or LPN and orders from a primary care provider.



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- **Home Maintenance and Chores**-Available through the MyCare waiver, this service covers minor home repairs, cleaning, hazard removal, and upkeep of modifications or devices, with a limit of \$10,000 per year.
- **Home Medical Equipment and Supplies**-Allows purchase of medical equipment and supplies to enhance independence, with services approved per item.
- **Home Modifications**- Funds to make physical changes to a home, such as installing ramps or handrails, to increase accessibility and independence, up to \$10,000 annually.
- **Self-Directed Goods and Services**-Provides up to \$2,500 annually for non-covered services, equipment, and supplies like camps, gym memberships, and appliance purchases.
- **Alternative Meals**-Allows selection of meal suppliers, including grocery stores and restaurants, for home delivery of meals.

H. Transportation services

How to schedule a ride:

- Call toll-free at 888-889-0929 (TTY 711) **48 hours, or two business days**, prior to your scheduled routine appointment.
- Reservations can be made up to 30 days in advance. Reservations for repeat appointments such as dialysis, chemotherapy, or radiation can be scheduled for a period of 90 days at a time.
- For an urgent/same day appointment or facility discharge, members may call the transportation services toll-free reservation line at 888-889-0929 (TTY 711), 24 hours a day, seven days a week.

You will need to provide the following information when calling transportation services:

- Your plan member ID number (located on your member ID card)
- Your full name
- Your date of birth
- Your current address
- Your phone number
- Details for pick-up address and drop-off of appointment address
- Specific appointment date and time

Who can call to schedule a ride?

- Members



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- An authorized representative
- The member's caregiver, a case manager, or other medical providers and/or facilities (such as hospitals)

How will you get to your appointment?

Types of vehicles that may be used for transportation include:

- Car
- Taxi
- Ride-sharing vehicle
- Wheelchair lift-equipped van

The type of vehicle used will be based on your mobility and physical needs. You can specify special needs or special instructions during the call intake. You will need to be ready 15 minutes before your scheduled pickup time.

Ambulatory members can request the rideshare option or a bus pass. If you have someone who can drive you to and/or from your appointment, you can request mileage reimbursement when scheduling your ride.

How will you get home from your appointment?

- If you call for a ride after your appointment, the driver should pick you up within 30 minutes.

How can you cancel or reschedule a ride?

- To cancel or reschedule a transport call 888-889-0929 (TTY 711).

Access for members with special needs:

Anthem plan providers and hospitals should help members with disabilities receive the care they need. If you use a wheelchair, walker, or other aid and need help entering an office:

- Make sure your provider's office knows this before you go to your appointment. This will help them be ready for your visit.
- Call Member Services if you want help talking to your doctor about your special needs.

In addition to the transportation assistance that Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) provides, you can still get help with transportation for certain services through the Non-Emergency Transportation (NET) program. Call your local County Department of Job and Family Services for questions or assistance with NET services.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 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 PCP. 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 1-833-727-2169 (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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 MyCare Ohio Full Dual 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 you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

If it isn't 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.

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 MyCare Ohio Full Dual 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.

13. Care during a disaster

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

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

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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.

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 doesn't 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

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 (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 care 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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

If you're part of a study that Medicare **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

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).



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 **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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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'll 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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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If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

A. Your covered services

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

Because you get help from Medicaid, 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 1-833-727-2169 (TTY 711)

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 this *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 Ohio Medicaid covered services according to the rules set by Medicare and Ohio Medicaid.
- 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.
- 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 your 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 care provider (PCP) or a care team providing and managing your care.
- When you are new to Anthem, we will make sure you can keep getting the care you need. You can continue seeing your current providers during a special time called the "continuity of care" period. This ensures that you retain access to services consistent with your previous plan of care.
- If you need help finding providers in our network, a Care Coordinator will assist you during your Person-Centered Planning Process.
- 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 in italic font.
- If your 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 costs of Original Medicare, go to your 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 Ohio Medicaid eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP). When your Ohio Medicaid coverage ends, we won't pay for your Ohio Medicaid 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 Ohio Medicaid eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

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

We'll assist you to regain your Ohio Medicaid eligibility. If your Ohio Medicaid eligibility is restored while you're still enrolled with us for your Medicare coverage, your enrollment with us



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

will continue. We'll resume paying for your Ohio Medicaid 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 Ohio Medicaid within six months we'll disenroll you from Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP). If you regain Ohio Medicaid 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:
 - o Polyarteritis nodosa,



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- 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;
- Chronic kidney disease (CKD):



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- o CKD requiring dialysis/End-stage renal disease (ESRD), and
 - o CKD not requiring dialysis;
- Severe hematologic disorders:
 - o Aplastic anemia,
 - o Hemophilia,
 - o Immune thrombocytopenic purpura,
 - o Myelodysplastic syndrome,
 - o Sickle-cell disease (excluding sickle-cell trait), and
 - o Chronic venous thromboembolic disorder;
- HIV/AIDS;
- Chronic lung disorders:
 - o Asthma,
 - o Chronic bronchitis,
 - o Cystic Fibrosis,
 - o Emphysema,
 - o Pulmonary fibrosis,
 - o Pulmonary hypertension, and
 - o Chronic Obstructive Pulmonary Disease (COPD);
- Chronic and disabling mental health conditions:
 - o Bipolar disorders,
 - o Major depressive disorders,
 - o Paranoid disorder,
 - o Schizophrenia,
 - o Schizoaffective disorder,
 - o Post-traumatic stress disorder (PTSD),
 - o Eating Disorders, and
 - o Anxiety disorders;



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- 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,
 - o Paralysis,



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- 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
	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; This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Acupuncture (continued) - 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. <i>Talk to your provider to get a prior authorization.</i>	



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Covered Service	What you pay
 Alcohol misuse screening and counseling We pay for one alcohol-misuse screening for adults who misuse alcohol but aren't 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're able and alert during counseling) with a qualified primary care provider (PCP) or practitioner in a primary care setting.	\$0
Ambulance and wheelchair van 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 or wheelchair van. 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
Asthma and COPD Relief Catalog - Value-Added Benefit Members will be able to select up to two items from a custom catalog containing a variety of asthma and COPD relief solutions such as: • inhaler vaporizer kits • travel nebulizer • hypoallergenic bedding • pillow covers and mattress covers • HEPA air filters • asthma monitoring devices Members diagnosed with asthma or COPD are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$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



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Covered Service	What you pay
 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 also cover intensive cardiac rehabilitation programs, which are more intense than cardiac rehabilitation programs. We cover these comprehensive programs if you've had at least one of these conditions: • heart attack in the last 12 months • 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>	\$0



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Covered Service	What you pay
 Cardiovascular (heart) disease risk reduction visit (therapy for heart disease) We pay for one visit a year, or more if medically necessary, with your primary care provider (PCP) to help lower your risk for heart disease. During the visit, your doctor may: • discuss aspirin use, • check your blood pressure, and/or • give you tips to make sure you're 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
Care Management Care Management is designed to respond to a member's needs when the member's condition or diagnoses require care and treatment for short and long periods of time. Care Managers will complete member screening and assessment tools to help identify holistic care needs, and gaps in care. This includes the Comprehensive Health Assessment. Care Managers will use information from the assessment to help the Member and their care team decide the proper care management services needed for an individualized plan of care approach. Member advocates or outreach specialists may attempt to contact members for Care Management Services. If a member is receiving care management services from other sources (e.g., a community services organization and other care management services), the care plan will define a process for managing medical, behavioral health, and/or substance abuse, and social aspects of care. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Care Management (continued) A signed member release may be needed in certain situations to openly discuss specific health concerns with the Member's care team, including their PCP.	
Caregiver Flex Funds This program may provide limited financial support for approved items or services that help make caregiving easier, safer, or less stressful for caregivers of Anthem MyCare members. A Caregiver Support coordinator will review the caregiver's needs and explain what support may be available. Eligibility, limits, and approval requirements may apply, so caregivers should ask before making purchases. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</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 <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
 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 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 This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Colorectal cancer screening (continued) non-invasive stool-based colorectal cancer screening test returns a positive result. Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
Community Resource Link - Value Added Benefit This is an online resource which locates and displays all available local community-based programs, benefits, and services. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Cooking at Home Catalog - Value-Added Benefit Members can select one item from a custom cooking catalog, such as: an air fryer, blender, toaster, utensils, and more. Members diagnosed with diabetes or hypertension are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
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



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Covered Service	What you pay
Dental Services - Supplemental This plan provides additional dental coverage not covered by Original Medicare. The following approved services are covered under your dental benefits: Diagnostic and Preventive Services: • Exams • X-rays • Cleanings (one every 6 months) • 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 and other gum-related treatments) • Removable Prosthodontics (complete or partial dentures, denture repairs, and related services) • Oral and Maxillofacial Surgery (teeth extractions, surgical repairs, and other related specialized procedures) • Adjunctive General Services (emergency treatment, sedation, anesthesia, night guards) • Maxillofacial Prosthetic Services • Limited Implant Services (implant maintenance and repair services) Please note: • Prior authorization is required for most comprehensive services prior to treatment being performed. Services must 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) 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. <i>Talk to your provider to get a prior authorization.</i>	
 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're overweight and have a family history of diabetes. You may qualify for up to 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 Library Membership and eReader - Value-Added Benefit Members receive a digital library card and an eReader. Members diagnosed with Alzheimer's or LTSS waiver members are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</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 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) • crutches • powered mattress systems • diabetic supplies • hospital beds ordered by a provider for use in the home • intravenous (IV) infusion pumps and pole • speech generating devices • oxygen equipment and supplies • nebulizers • walkers • standard curved handle or quad cane and replacement supplies • cervical traction (over the door) • bone stimulator • dialysis care equipment • Medically necessary devices, such as speech synthesizers, that help members with limited vocal or verbal communication skills convey their thoughts are covered in accordance with Ohio Medicaid requirements. • Medically necessary disposable medical equipment is covered in accordance with Ohio Medicaid requirements. Members should talk to their provider if they need disposable medical 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/oh/mycare. This benefit is continued on the next page.	



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Covered Service	What you pay
Durable medical equipment (DME) and related supplies (continued) 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>	
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. World-wide emergency/urgent care - Supplemental: This benefit is continued on the next page.	\$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
Emergency Care (continued) 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. Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. 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.	
Emotional Well-being Resource - Value-Added Benefit Members receive unlimited access to the online community which promotes behavioral health and wellness through instruction, coaching, goal setting and monitoring. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Everyday Options Allowance - Supplemental This benefit provides a combined spending allowance of \$275 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. 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) If you qualify for Special Supplemental Benefits for the Chronically Ill (SSBCI), you may also be able to use this allowance on: • Hair Care and Grooming Services. • 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: • Pay in-store at participating retailers near you (OTC, Healthy Foods, and Hair Care and Grooming Services 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: - o Including further detail on how to use your benefits and your Benefits Prepaid Card - o 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 This benefit is continued on the next page.	



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Covered Service	What you pay
Everyday Options Allowance - Supplemental (continued) 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 are subject to availability. Quantity limits may apply. Installation services are not included. Any repair or replacement is limited to the manufacturer's warranty. - Once you reach your monthly spending allowance, you are responsible for the remaining cost of your purchases. - You 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.	
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 This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Family planning services (continued) - 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	
Federally qualified health centers The plan covers the following services at federally qualified health centers: - office visits for primary care and specialist services - physical therapy services - speech pathology and audiology services - dental services This benefit continues on the next page.	\$0



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Covered Service	What you pay
Federally qualified health centers (continued) • podiatry services • optometric and/or optician services • chiropractic services • transportation services • mental health services • nurse practitioners • physicians assistants • certified nurse-midwives • visiting nurses • registered dieticians • nutritional professionals Note: You can get services from a network or out-of-network federally qualified health center.	
Fresh Food Connect - Value-Added Benefit Members can select one of the following options: • three boxes of farm-fresh produce delivery • annual Sam's Club membership • annual Costco membership • \$150 Healthy Grocery gift card Members diagnosed with cardiovascular disease, hypertension, or obesity are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0



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Covered Service	What you pay
Get Connected to Health - Value-Added Benefit The Get Connected to Health program gives members a free smart cell phone preloaded with digital health apps and resources for quick access to care. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
 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 Home - Value-Added Benefit Members receive up to \$125 to use toward one of the following in-home services: • Pest control treatments to reduce pests in the home • Carpet cleaning services to help mitigate asthma triggers Members diagnosed with asthma are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Healthy Meals - Post-Discharge - Supplemental This plan covers up to 2 meals a day for 21 days (maximum 42 meals) following your discharge from the hospital or skilled nursing facility (SNF).	\$0 Any costs you pay for Medicare Non-covered



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Covered Service	What you pay
Healthy Meals - Post-Discharge - Supplemental (continued) 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.	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. Medically necessary cochlear implants are covered in accordance with Ohio Medicaid requirements. Ohio Medicaid eligibility criteria, coverage limitations, and prior authorization requirements may apply. <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 benefit is continued on the next page	\$0 Any costs you pay for Medicare Non-covered Services will not count



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Covered Service	What you pay
Hearing services - Supplemental (continued) 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 \$3,000 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>	toward your maximum out-of-pocket amount.
 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. This benefit continues on the next page.	\$0



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Covered Service	What you pay
 HIV screening (continued) If you're pregnant, we pay for up to three HIV screening tests during a pregnancy.	
Home and community-based waiver services The plan covers the following home and community-based waiver services: • adult day health services • alternative meals service • choices home care attendant • chore services • community transition • enhanced community living services • home care attendant • home delivered meals • home medical equipment and supplemental adaptive and assistance device services • home modification, maintenance, and repair • homemaker services • independent living assistance • nutritional consultation • out-of-home respite services • personal care aide services • personal emergency response services This benefit is continued on the next page	These services are available only if your need for long-term care has been determined by the Ohio Department of Medicaid. You may be responsible for paying a patient liability for waiver services. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.



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Covered Service	What you pay
Home and community-based waiver services (continued) • pest control • social work counseling • Structured Family Caregiving (SFC) • waiver nursing services • waiver transportation	
Home health agency care Before you can get home health services, a doctor must tell us you need them, and they must be provided by a home health agency. You must be homebound, which means leaving home is a major effort. We pay for the following services, and maybe other services not listed here: • part-time or intermittent skilled nursing and home health aide services (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 • Medically necessary home health and nursing services, including private duty nursing and registered nurse assessment and consultation services, are covered in accordance with Ohio Medicaid requirements. <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
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. 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>	\$0
Home Safety Benefit - Value-Added Benefit Members can select up to two home safety items, such as: - anti-slip tape for stairs, night lights, nonskid tub mat, nonslip bathroom floor mat, carpet tape for rugs, door alarms, smoke This benefit continues on the next page.	\$0



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Covered Service	What you pay
Home Safety Benefit - Value-Added Benefit (continued) alarms, carbon monoxide detectors, medication lock boxes, fire extinguishers, water filtration kits, radon detectors, and mold tests <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	
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 • nursing facility 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: This benefit is continued on the next page.	\$0 If you want hospice services in a nursing facility, you may be required to use a network nursing facility. Also, you may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.



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Covered Service	What you pay
Hospice care (continued) - 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 <i>Member Handbook</i>. 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 hasn't chosen the hospice benefit. <i>Talk to your provider to get a prior authorization.</i>	
Housing Stability This referral program is designed to find safe and stable housing for members experiencing homelessness or at risk of homelessness. This program may also offer other social support(s) to eliminate stable housing barriers, (e.g. rental/utility arrears, security deposits, furniture needs). <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
 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) - vaccines for children under age 21 - 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. The shingles shot is only covered under the Part D drug benefit. The amount you pay for the shot will depend on the Part D drug benefits found in Chapter 6. The shingles shot is not covered under the Part B drug benefit.	
Industry Certification Assistance - Value-Added Benefit Members receive a \$100 gift card to help cover the cost of industry certifications. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. 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



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Covered Service	What you pay
Inpatient hospital care (continued) We pay for the following services and other medically necessary services not listed here: • semi-private room (or a private room if medically necessary) • meals, including special diets • regular nursing services • costs of special care units, such as intensive care or coronary care units • drugs and medications • lab tests • X-rays and other radiology services • needed surgical and medical supplies • appliances, such as wheelchairs • operating and recovery room services • physical, occupational, and speech therapy • inpatient substance abuse 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. • Medically necessary inpatient reconstructive surgery to correct abnormalities caused by birth defects, developmental abnormalities, trauma, injury, infection, tumors, or disease is covered in accordance with Ohio Medicaid requirements. Covered reconstructive procedures may include, but are not limited to, cleft palate repair and breast reconstruction. • For members receiving medically necessary Swing Bed services, Anthem covers the first 45 days of care. If the stay exceeds 45 days, the member will be disenrolled from Anthem, and the remainder of the stay will be covered by This benefit continues on the next page.	after your emergency is stabilized.



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Covered Service	What you pay
Inpatient hospital care (continued) Ohio Medicaid, in accordance with applicable Ohio Medicaid program requirements. If you need a transplant, a Medicare-approved transplant center will review your case and decide if you're 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 treatment/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 This benefit continues on the next page.	



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Covered Service	What you pay
Inpatient hospital care (continued) (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. • physician services Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you're not sure if you're an inpatient or an outpatient, ask the 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 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>	
Inpatient services in a psychiatric hospital We pay for mental health care services that require a hospital stay. • inpatient psychiatric care in a private or public free-standing psychiatric hospital or general hospital - o For members 22-64 years of age in a freestanding psychiatric hospital with more than 16 beds, there's a 190-day lifetime limit • inpatient detoxification care • There is a 190-day lifetime limit for inpatient services in a psychiatric hospital. • The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Inpatient services in a psychiatric hospital (continued) 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>	
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 • prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that replace all or part of: - o an internal body organ (including contiguous tissue), or - o 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 This benefit is continued 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) 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 this <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 - 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.	\$0



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Covered Service	What you pay
 Lung cancer screening with low dose computed 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 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.	\$0
 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. Medical Nutrition Therapy services may be ordered by a physician, physician assistant (PA), or advanced practice registered nurse (APRN). A registered dietitian must develop and approve the treatment plan in accordance with Ohio Medicaid requirements.	\$0



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Covered Service	What you pay
 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
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 doesn't cover them This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Medicare Part B drugs (continued) • osteoporosis drugs that are injected. We pay for these drugs if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't 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 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) This benefit is continued on the next page.	



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Covered Service	What you pay
Medicare Part B drugs (continued) • 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: www.anthem.com/oh/mycare 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>	
Movie Night Package - Value-Added Benefit Members can receive a movie night package which includes a \$50 movie gift card and a \$50 restaurant gift card to help reduce social isolation. Members discharged from a Nursing facility and approved by Care Management are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0



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Covered Service	What you pay
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.
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. 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 • X-rays and other radiology services usually given by nursing facilities • use of appliances, such as wheelchairs usually given by nursing facilities This benefit is continued on the next page.	\$0 You may be responsible for paying a patient liability for nursing facility services, after the Medicare nursing facility benefit is used. The County Department of Job and Family Services will determine if your income and certain expenses require you to have a patient liability.



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Covered Service	What you pay
Nursing facility care (continued) • physician/practitioner services • durable medical equipment • dental services, including dentures • vision benefits • hearing exams • chiropractic care • podiatry services You usually get your care from network facilities. However, you may be able to get your care from a facility not in our network. You can get care from the following places if they accept our plan's amounts for payment: • a nursing home or continuing care retirement community where you lived on the day you became a Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) member • 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. Anthem covers the first 180 days of medically necessary care in a nursing facility. On the 181st day, the member will be disenrolled from Anthem, and the remainder of the stay will be covered by Ohio Medicaid in accordance with applicable Ohio Medicaid program requirements. <i>Talk to your provider to get a prior authorization.</i>	
 Obesity screening and therapy to keep weight down If you have a body mass index of 30 or more, we pay for counseling to help you lose weight. You must get the counseling in a primary care setting. That way, it can be managed with your full prevention plan. Talk to your primary care provider to find out more.	\$0



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Covered Service	What you pay
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 counseling • individual and group therapy • testing for drugs or chemicals in your body (toxicology testing) <i>Talk to your provider to get a prior authorization.</i>	\$0
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 This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Outpatient diagnostic tests and therapeutic services and supplies (continued) 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 test called echocardiograms, lab tests, genetic test, sleep studies and related supplies. <i>Talk to your provider to get a prior authorization.</i>	
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. 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>	\$0
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 This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Outpatient hospital services (continued) • Labs and diagnostic tests billed by the hospital • chemotherapy • 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>	
Outpatient mental health care We pay for mental health services provided by: • a state-licensed psychiatrist or doctor • a clinical psychologist • a clinical social worker (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 The plan covers the following services, and maybe other services not listed here: • clinic services and general hospital outpatient psychiatric services • Therapeutic Behavior Services (TBS) • psychosocial rehab services This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Outpatient mental health care (continued) Medically necessary neurotherapy (also referred to as neurofeedback or EEG biofeedback) is covered when provided by a licensed Qualified Mental Health Professional (QMHP) acting within the scope of their practice. Biofeedback treatment helps people improve their health by using signals from their own bodies. A certified biofeedback technician may assist in providing biofeedback treatment; however, the related psychotherapy must be provided by a QMHP. Ohio Medicaid coverage limitations apply. <i>Talk to your provider to get 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 - extended-release Naltrexone (vivitrol) treatment <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
Outpatient surgery We pay for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. Medically necessary outpatient reconstructive surgery is covered in accordance with Ohio Medicaid requirements. Cosmetic surgery performed solely to improve appearance or self-esteem is not covered. 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
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 federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, 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. <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
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 the 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 care provider or specialist, if your doctor orders them to find out whether you need treatment This benefit is continued on the next page.	\$0



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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 to 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 is continued 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 • Medically necessary genetic counseling, diagnostic genetic testing, and follow-up for members with known or suspected genetic disorders are covered in accordance with Ohio Medicaid requirements. Experimental genetic testing, blood typing for paternity testing, and prenatal testing performed solely to determine the sex of the baby are not covered. <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 This benefit continues on the next page.	\$0



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Covered Service	What you pay
Podiatry services (continued) <i>Talk to your provider to get a prior authorization.</i>	
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 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
 Prostate cancer screening exams For men aged 50 and over, we pay for the following services once every 12 months: • a digital rectal exam This benefit continues on the next page.	\$0



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Covered Service	What you pay
 Prostate cancer screening exams (continued) a prostate specific antigen (PSA) test	
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) - dental devices 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
Rural health clinics The plan covers the following services at rural clinics: • office visits for primary care and specialist services • clinical psychologist • clinical social worker for the diagnosis and treatment of mental illness • visiting nurse services in certain situations Note: You can get services from a network or out-of-network rural health clinic. <i>Talk to your provider to get a prior authorization.</i>	\$0
 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



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Covered Service	What you pay
SDOH Flex Funds This benefit offers a one-time financial support to help with eligible expenses. These funds can help remove barriers related to housing, employment, education, and other social needs. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Sensory Solutions - Value-Added Benefit Members can receive a \$100 gift card to purchase sensory products. Members diagnosed with anxiety, depression, autism, or ADD/ADHD are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</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 care provider must order the tests. We cover these tests once every 12 months or at certain times during pregnancy. We also pay for up to two face-to-face, high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. Each session can be 20 to 30 minutes long. We pay for these counseling sessions as a preventive service only if given by a primary care provider. The sessions must be in a primary care setting, such as a doctor's office.	\$0



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Covered Service	What you pay
SilverSneakers® Membership SilverSneakers® can help you live a healthier, more active life through fitness and social connection. You are covered for a fitness benefit through SilverSneakers online and at participating locations.¹ You have access to a nationwide network of participating locations where you can take 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. ¹Participating locations (PL) are not owned or operated by Tivity Health, Inc. or its affiliates. Use of PL facilities and amenities is limited to terms and conditions of PL basic membership. Facilities and amenities vary by PL. ²Membership includes SilverSneakers instructor-led group fitness classes. Some locations offer members additional classes. Classes vary by location. SilverSneakers is not a gym membership, but a specialized program designed specifically for older adults. Gym memberships or other fitness programs that do not meet the SilverSneakers criteria are excluded. SilverSneakers is a registered trademark of Tivity Health, Inc. All rights reserved. Tivity Health, Inc. is an independent company providing a fitness program on behalf of this plan.	\$0 Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Covered Service	What you pay
Skilled nursing facility (SNF) care For a definition of skilled nursing facility care, go to Chapter 12. We pay for the following services, and maybe other services not listed here: • a semi-private room, or a private room if it's 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 • X-rays and other radiology services given by nursing facilities • appliances, such as wheelchairs, usually given by nursing facilities • physician/provider services • For members receiving medically necessary Swing Bed services, Anthem covers the first 45 days of care. If the stay exceeds 45 days, the member will be disenrolled from Anthem, and the remainder of the stay will be covered by Ohio Medicaid, in accordance with applicable Ohio Medicaid program requirements. 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: This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Skilled nursing facility (SNF) care (continued) • 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 Anthem covers the first 180 days of medically necessary care in a nursing facility. On the 181st day, the member will be disenrolled from Anthem, and the remainder of the stay will be covered by Ohio Medicaid in accordance with applicable Ohio Medicaid program requirements. <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.)	\$0
Special Care Management - SMI Determinations Anthem covers special care management services for the following groups: adults with special healthcare needs and adults with serious mental illness (SMI)*. This benefit continues on the next page.	\$0



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Covered Service	What you pay
Special Care Management - SMI Determinations (continued) *SMI determination must be completed by a qualified Anthem provider. Upon determination, Medicaid members who are diagnosed as being SMI can choose to disenroll from Anthem and continue to receive benefits through Medicaid. Annually, Medicaid members diagnosed as SMI will be evaluated, and a new determination will be made. If the evaluation does not result in a redetermination as SMI, the Medicaid member who chose to disenroll from Anthem will be re-enrolled as of the first day of the next possible month.	
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. • Hair Care and Grooming Service* • 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.
SUD Recovery Support - Value-Added Benefit SUD Recovery Support Members can receive access to our Substance Use Disorder Recovery Support program, which is a mobile platform that provides daily motivation/check-in, moderated peer support groups, secure messaging with clinicians and recovery coaches, appointment and medication reminders, This benefit continues on the next page.	\$0



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Covered Service	What you pay
SUD Recovery Support - Value-Added Benefit (continued) and educational content to support ongoing recovery. Members who are referred to the SUD program by a Case Manager are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	
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 specialist (CNS) trained in both basic and advanced life support techniques <i>Talk to your provider to get a prior authorization.</i>	\$0



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Covered Service	What you pay
Transportation - Community Transportation - Value-Added Benefit Members receive up to 60 one-way rides to community resources and services (within 30 miles of their location). Note: Health-related trips are covered under the Medicare Supplemental Transportation benefit. See Transportation - Supplemental for details. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Transportation Essentials - Value-Added Benefit Members can select a \$100 gift card for one of the following transportation options: • Bus pass • Gas card • Rideshare card Members with Care Management approval are eligible for this benefit. <i>Talk to your care coordinator to get more information about eligibility, limits, and approval requirements.</i>	\$0
Transportation - Supplemental This plan offers coverage for unlimited 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 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) 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 • 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's not possible, or it's unreasonable to get this service from network providers (for example, when you're outside the plan's service area and you This benefit is continued on the next page.	\$0



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Covered Service	What you pay
Urgently needed care (continued) require medically needed immediate services for an unseen condition but it's not a medical emergency). World-wide emergency/urgent care - Supplemental: 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 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. Any costs you pay for Medicare Non-covered Services will not count toward your maximum out-of-pocket amount. 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.	
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 member ID card ready when you sign up. Benefits of a video doctor visit: 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) • The visit is just like seeing your regular doctor face-to-face, but just by web camera. • It's a great option for medical care when your doctor can't see you. Board-certified doctors can help 24/7 for most types of care and common conditions like the flu, colds, pink eye and more. • The doctor can send prescriptions to the pharmacy of your choice, if needed.¹ • If you're feeling stressed, worried, or having a tough time, you can make an appointment to talk to a licensed therapist or psychologist from your home or on the road. In most cases, you can make an appointment and talk with a 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, This benefit is continued on the next page.	\$0



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Covered Service	What you pay
 Vision care (continued) treatment for age-related macular degeneration and vision training. 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 and 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 have two separate cataract surgeries, you must get one pair of glasses after each surgery. You can't get two pairs of glasses after the second surgery, even if you didn't 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. Refractions are covered as part of a routine eye exam and are not covered if billed separately. This plan covers up to \$450 for eyeglasses or contact lenses every year. The amount the plan covers for eyewear is deducted from the total charged amount billed to insurance. After plan paid benefits for eyewear are applied, you are responsible for any remaining costs including non-covered services. Benefits available under this plan cannot be combined with any other in-store discounts.	\$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
 “Welcome to Medicare” preventive visit We cover the one-time “Welcome to Medicare” preventive visit. The visit includes: • a review of your health, • education and counseling about 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.	\$0
Well child check-up (also known as Healthchek) Healthchek is Ohio’s early and periodic screening, diagnostic, and treatment (EPSDT) benefit for everyone in Medicaid from birth to under 21 years of age. Healthchek covers medical, vision, dental, hearing, nutritional, development, and mental health exams. It also includes immunizations, health education, and laboratory tests.	\$0

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 Ohio 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.



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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

Exams - These are dental check-ups that help your dentist see if your teeth or gums are healthy or if there are any problems.

Code(s)	Service	How Often Is It Covered	Need Approval First?
D0120	Periodic oral exam	1 every 365 days	No
D0140	Limited problem-focused	As needed	No
D0150	Comprehensive	1 every 5 years per provider	No
D0180	Periodontal exam (for gum disease)	1 every 365 days	No

When it is covered:

- You haven't had an exam recently.
- The dentist needs to check for dental problems or create a treatment plan.

When it is not covered:

- You just had an exam and nothing has changed.
- The exam is only for cosmetic reasons.

Cleanings - These services help keep your teeth and gums healthy and prevent disease. You are covered for 1 cleaning every 6 months.

Diagnostic Services - These services help your dentist see inside your mouth and figure out what is wrong.



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Code(s)	Service	How Often Is It Covered	Need Approval First?
D0210	Full mouth X-rays	1 every 5 years per provider	No
D0270 - D0274	Bitewing X-rays (back teeth)	1 set every 6 months	No
D0330	Panoramic X-ray (full mouth in one picture)	1 every 5 years	No
D0220 / D0230	Small X-rays of a tooth	As needed	No
D0240	Top or bottom mouth X-ray	As needed	No
D0250	Side-view or jaw X-rays	As needed	No
D0321	Jaw joint X-rays (TMJ)	As needed	No
D0340	Head/face X-ray for braces	As needed	No
D0350	Photo inside or outside mouth	As needed	No
D0367	3D scan (cone beam CT)	1 every 5 year per provider	No
D0372 - D0389	Tomosynthesis scan	By report only	No
D0396	3D printing from dental scan	By report only	No
D0801 - D0804	3D facial scan	By report only	No

When it is covered:

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- X-rays are only done when your dentist needs them to help diagnose or treat a problem.
- X-rays should not be taken just because your insurance covers them.
- You don't need pre-approval before you get these done unless it says "Yes" for approval above.

When it is not covered:

- If X-rays are taken just because your plan allows them, but they're not needed, they will not be paid for.
- If they're blurry, missing labels, or poorly done, they may be denied.
- Some advanced scans (like 3D or CT scans) need special reasons and pre-approval.

Restorative Services - These services help fix teeth that are broken or have cavities (holes). This includes fillings, crowns, and other types of tooth repairs.

Fillings (Direct Restorations)

Code(s)	Service	How Often Is It Covered	Need Approval First?
D2140 - D2161	Silver fillings (1-4 surfaces)	As needed	No
D2330 - D2335	White fillings (front teeth)	As needed	No
D2390 - D2394	White fillings (back teeth)	As needed	No

When it is covered:

- You have a new cavity that goes into the dentin.
- A filling has fallen out or broken.
- There is visible damage or decay on X-rays.

When it is not covered:

- You want to replace a silver filling just to make it look better.
- The tooth is too broken down to fix.
- The tooth is already expected to fall out (baby tooth).



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Crowns (Full Tooth Coverings)

Code(s)	Service	How Often Is It Covered	Need Approval First
D2740, D2751, D2752, D2790, D2791, D2792	Crowns (metal or porcelain)	As needed	Yes

When it is covered:

- The tooth has large damage (more than 50%)
- You had a root canal and need full coverage.
- Your tooth is cracked or broken and cannot be fixed with a filling.

When it is not covered:

- You just want a crown to make your tooth look nicer.
- The tooth can be fixed with a filling.
- The tooth has less than 50% bone support or is very loose.

Core Buildups (Support for Crowns)

Code	Service	How Often Is It Covered	Need Approval First?
D2950	Core buildup	1 per tooth every 60 months	No

When it is covered:

- More than half the tooth is missing and a crown won't stay without it.

When it is not covered:

- The tooth isn't healthy enough to support a crown.

Post and Core (Support after Root Canal)

Code(s)	Service	How Often Is It Covered	Need Approval First
D2952, D2954	Post and core after root canal	As needed	Yes



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When it is covered:

- The tooth had a root canal.
- The post is needed to help hold a crown in place.

When it is not covered:

- The tooth is too damaged or loose.
- The tooth doesn't have enough healthy bones or root left.

Pin Retention (Pins to Hold Fillings)

Code	Service	How Often Is It Covered	Need Approval First?
D2951	Pin added to support a filling	3 pins max per tooth in a lifetime	No

When it is covered:

- A filling needs extra support and there's not enough healthy teeth left.

Endodontic Services (Root Canals and More) - These services treat the inside of your tooth, especially when the nerve is infected or damaged.

Root Canal Therapy (Permanent Teeth Only)

Code(s)	Service	How Often Is it Covered	Need Approval First?
D3310	Front tooth root canal	As needed	No
D3320	Bicuspid root canal	As needed	No
D3330	Molar	As needed	No

When It is covered:

- The nerve is infected, dead, or the tooth is broken down to the nerve.
- You are in pain or have swelling or visible infection.



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When It is not covered:

- The tooth is too damaged to save.
- The root is infected and won't heal even with a root canal.
- The tooth doesn't touch another tooth or denture and isn't needed for chewing.

Apexification (Help Young Teeth Finish Growing After Infection)

Code(s)	Service	How Often Is it Covered	Need Approval First?
D3351 - D3353	Apexification (3 stages)	As needed	No

When it is covered:

- The nerve is dead but the root hasn't finished growing.
- A special material is placed to help the root close.

Apicoectomy (Root-End Surgery for Front Teeth)

Code	Service	How Often Is it Covered	Need Approval First?
D3410	Apicoectomy (front teeth only)	As needed	No

When It is covered:

- A root canal failed and can't be fixed from the top.
- There's a broken root tip or persistent infection.

When It is not covered:

- The tooth is too damaged to save.
- There's no infection or reason to treat.

Please note: For all root canal services -

- X-rays before and after the treatment are required in your record.
- The tooth must have a good chance of staying healthy after treatment.
- If the treatment started before you had Medicaid, it may not be covered.



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Periodontic Services (Gum Treatments) - These services help treat gum disease and keep your gums and the bone around your teeth healthy.

Scaling and Root Planing (Deep Cleaning)

Code(s)	Service	How Often Is It Covered	Need Approval First?
D4341	Deep cleaning (4+ teeth per area)	1 per area every 24 months	Yes
D4342	Deep cleaning (1-3 teeth per area)	1 per area every 24 months	Yes

When it is covered:

- You have bone loss and pocket 4mm or deeper.
- Your gums are inflamed and there is plaque or calculus under the gums.
- A dentist has taken X-rays and a full gum chart.

When it is not covered:

- Just to clean teeth with no signs of gum disease.
- Done the same day as a regular cleaning or gum surgery in the same area.

Periodontal Maintenance (Follow-Up Care)

Code	Service	How Often Is It Covered	Need Approval First?
D4910	Cleaning for people with gum disease	1 every 365 days	No (if SRP was done in last 24 months)

When It is covered:

- You had a deep cleaning in the last 24 months.
- Your gum health is being maintained or improved.

When it is not covered:

- You never had deep cleaning.
- You had a regular cleaning or surgery in the same area too recently.



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Gum Surgery (Remove Excess Gum Tissue)

Code(s)	Service	How Often Is It Covered	Need Approval First?
D4210, D4211	Gum surgery for overgrowth	As needed	Yes

When it is covered:

- You had deep cleaning and still have gum pockets 5mm or deeper.
- There's extra gum tissue causing problems, not just for looks.

When it is not covered:

- Surgery is only to make your gums look better.
- It's done at the same time as another procedure in the same area.

Removal of Barrier (after gum surgery)

Code	Service	How Often Is It Covered	Need Approval First?
D4286	Removing a non-dissolving barrier	As needed	Yes

When it is covered:

- You had surgery that used a non-dissolving (non-resorbable) barrier.

When it is not covered:

- It's done at the same place that put the barrier in and no reason is given.

Please note: Gum treatments include local numbing (anesthesia), aftercare, and follow-ups. These can't be billed separately.

Removable Prosthodontic Services (Dentures and Partials) - These services replace missing teeth with removable false teeth. Dentures and partials help you chew, speak and smile again.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Complete and Immediate Dentures

Code(s)	Service	How Often Is It Covered	Need Approval First?
D5110	Full upper denture	1 every 8 years	Yes
D5120	Full lower denture	1 every 8 years	Yes
D5130	Immediate upper denture (after extractions)	1 every 8 years	Yes
D5140	Immediate lower denture (after extractions)	1 every 8 years	Yes

When it is covered:

- You have no teeth in that arch.
- Your current denture can't be fixed.
- You're having teeth pulled and need a denture right after.

When it is not covered:

- You already have a denture that still works.
- The issue is cosmetic or you don't plan to wear the denture.
- Your mouth is not ready (untreated teeth, infections, etc).

Code(s)	Service	How Often Is It Covered	Need Approval First?
D5211 - D5214, D5225 - D5226	Upper and lower partial dentures (various types)	1 every 8 years	Yes

When it is covered:

- You're missing multiple teeth and chewing or appearance is affected.



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- Your remaining teeth are healthy and will support the appliance.

When it is not covered:

- You're only missing back teeth that don't affect chewing or looks.
- You still need extractions, fillings, or gum treatments.
- You have gum disease or weak teeth that won't support a denture.

Denture Repairs and Add-Ons

Code(s)	Service	How Often Is It Covered	Need Approval First?
D5511 - D5660	Fix broken parts, add teeth or clasps	As needed	No

When it is covered:

- A denture or partial breaks or need a new tooth or clasp.
- A tooth was pulled and needs to be added to an existing denture.

When it is not covered:

- The denture is less than 6 months old (it's under warranty).
- You used self-curing materials or at-home fixes.

Relines (Make Denture Fit Better)

Code(s)	Service	How Often Is It Covered	Need Approval First?
D5750 - D5761	Reline full or partial denture	1 every 3 years	No

When it is covered:

- Your denture is loose and causes problems.
- The reline uses proper dental lab materials.

When it is not covered:

- It's done within 6 months of getting a new denture (already covered).



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- At-home reline kits or materials are used.

Please note: Denture services include the full process from impressions to delivery. All repairs, relines, and follow-ups for 6 months are included in the original cost.

Implant Services - These services help maintain, repair, or remove an existing dental implant. You are covered for some dental implant services when medically necessary. Prior authorization is required.

Code(s)	Service	How Often Is It Covered	Need approval First?
D6089	Accessing and retorquing loose implant screw, per screw	By report	Yes
D6105	Removal of implant body not requiring bone removal or flap elevation	As needed	Yes
D6106	Guided tissue regeneration, resorbable barrier, per implant	As needed	Yes
D6107	Guided tissue regeneration, non-resorbable barrier, per implant	As needed	Yes
D6197	Replacement of restorative material, close access opening of screw-retained implant supported prosthesis, per implant	As needed	Yes

Oral Surgery Services - Oral surgery includes removing teeth, fixing jaw problems, and treating issues like infections or cysts to keep your mouth healthy.



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Tooth Extractions

Code(s)	Service	How Often Is It Covered	Need Approval First?
D7140	Simple tooth removal	1 per tooth in a lifetime	No
D7210	Surgical removal of tooth with bone removal	1 per tooth in a lifetime	No
D7220	Surgical removal of impacted tooth (under the gum)	1 per tooth in a lifetime	Yes, only for wisdom teeth
D7230	Surgical removal of impacted tooth (partially under the bone)	1 per tooth in a lifetime	No
D7240 - D7241	Surgical removal of impacted tooth (fully under the bone)	1 per tooth in a lifetime	Yes
D7250	Removal of root tips	1 per tooth in a lifetime	Yes

When it is covered:

- The tooth is broken, decayed, or infected and cannot be saved.
- It causes pain, swelling, or interferes with other teeth or dentures.

When it is not covered:

- It's for cosmetic reasons or to help with braces (unless medically needed).
- There's no sign of disease or problem.

Alveoloplasty (Smoothing Bone After Extractions)

Code(s)	Service	How Often Is It Covered	Need Approval First?
D7310, D7311	Bone reshaping (with extractions)	1 per quadrant in a lifetime	No



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D7320, D7321	Bone reshaping (without extractions)	1 per quadrant in a lifetime	No
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When it is covered:

- Bone needs to be smoothed to help fit a denture or avoid future problem.

When it is not covered:

- It's done just to improve appearance.

Other Surgical Services

Code(s)	Service	How Often Is It Covered	Need Approval First?
D7510 - D7520	Drainage of abscess	As needed	No
D7530 - D7560	Removal of cysts or growths	As needed	Yes but only D7509
D7960 - D7963	Fenectomy/Frenuloplasty (removing tissue under tongue/lip)	As needed	Yes
D7971	Excision of pericoronal gingiva	As needed	Yes

When it is covered:

- There are medical reasons like infection, speech problems, or difficulty eating.

When it is not covered:

- The goal is only to improve how things look.
- It's part of another procedure already being done (like extractions or deep cleaning).

Please note: Surgery includes all related X-rays, local anesthesia, and follow-up care. These are part of the service and cannot be billed separately.

Adjunctive General Services - These are extra services that help support your dental care. They include emergency visits, anesthesia, and services for members with special health needs.



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Emergency and Palliative Treatment

Code	Service	How Often Is It Covered	Need Approval First?
D9110	Emergency dental care to relieve pain	As needed	No

When it is covered:

- You have urgent dental pain, swelling, or infection.
- The dentist treats the pain right away, not just gives medication.

Anesthesia and Sedation

Code(s)	Service	How Often Is It Covered	Need Approval First?
D9222 - D9223	General anesthesia (put to sleep)	1 per day	No
D9230	Inhalation sedation (like nitrous oxide/laughing gas)	As needed	Yes
D9243	IV sedation	4 per day	Yes

When it is covered:

- The procedure is complex or painful.
- You are unable to tolerate dental treatment due to age, medical condition, or disability.

When it is not covered:

- Used just to reduce anxiety with no medical reason.
- Another type of anesthesia would have worked.



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Behavior Management

Code	Service	How Often Is It covered	Need Approval First?
D9920 / D9997	Care coordination and behavior management	As needed	Yes

When it is covered:

- A member has a physical or mental condition that makes dental care difficult.
- The dentist needs to spend extra time and care to safely complete treatment.

Non-Covered Services and General Rules:

- Cosmetic services (just to improve appearance) are not covered.
- Services that are not medically necessary will be denied.
- If you get a service without required approval, it might not be paid.
- The dentist must show why the service is needed, using X-rays or pictures, if asked.
- You are not responsible for sending this information - your dentist takes care of that.

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 our 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.



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- Fees for missed appointments, preparing or copying dental reports, duplicate X-rays, itemized bills, or claim forms are not covered.

Our 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.

D1. Non-emergency medical transportation

We cover non-emergency medical transportation under 60 miles. Contact your county department of job and family service for transportation at jfs.ohio.gov/about/local-agencies-directory

E. Benefits not covered by our plan, Medicare, or Medicaid

This section tells you about benefits excluded by our plan. "Excluded" means that we don't pay for these benefits. Medicare and Medicaid 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:

- services considered not "reasonable and medically necessary," according to Medicare and Medicaid standards, unless we list these as covered services
- experimental medical and surgical treatments, items, and drugs, unless Medicare, a Medicare-approved clinical research study, or our plan covers them. Refer to **Chapter 3** of 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.



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- surgical treatment for morbid obesity, except when medically necessary and Medicare pays for it
- a private room in a hospital, except when medically necessary
- personal items in your room at a hospital or a nursing facility, such as a telephone or television
- fees charged by your immediate relatives or members of your household
- elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary
- cosmetic surgery or other cosmetic work, unless it'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
- 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'll reimburse the veteran for the difference. You're still responsible for your cost-sharing amounts.
- paternity testing
- services to find cause of death (autopsy) or services related to forensic studies
- assisted suicide services, defined as services for the purpose of causing, or assisting to cause, the death of an individual
- biofeedback services, except neurotherapy (also referred to as neurofeedback or EEG biofeedback), which may be covered when certain requirements are met.
- inpatient treatment to stop using drugs and/or alcohol (in-patient detoxification services in a general hospital are covered)



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- sexual or marriage counseling



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Medicaid. 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 are in Medicare hospice. For more information, please refer to **Chapter 5, Section F** "If you're 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 care provider (PCP). It could also be another provider if your PCP has referred you for care.

Your prescriber must **not** be on Medicare's Exclusion or Preclusion Lists, and the **Ohio Medicaid Provider Exclusion and Suspension List**.

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

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



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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, look in the *Provider and Pharmacy Directory*, visit our website, or contact Member Services.



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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 isn't 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 List of Covered Drugs.



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

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling the 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 is important that you respond each time you are contacted by the pharmacy, to let them know what to do with the new prescription and to prevent any delays in shipping.

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

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



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

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

If you used mail-order in the past and don't 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 program that automatically prepares mail-order refills, contact us by calling 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.

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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 also 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 and some prescription and over-the-counter (OTC) drugs and products covered under Medicaid.

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:

- Visit our plan's website at www.anthem.com/oh/mycare. The Drug List on our website is always the most current one.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 <https://shop.anthem.com/medicare> 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 Medicaid 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 Medicaid 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
- 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



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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

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



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- We usually don't pay for the brand name drug 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/oh/mycare 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/oh/mycare 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/oh/mycare. 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:

- 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.



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- 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 isn't on our *Drug List* or is limited in some way. This gives you time to talk with your provider about getting a different drug or to ask us to cover the drug.

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

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



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

D2. Asking for a temporary supply

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

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

- Change to another drug.

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

OR

- Ask for an exception.

You and your provider can ask us to make an exception. For example, you can ask us to cover a drug that isn't 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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're 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/oh/mycare 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.
 - 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.



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- 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.

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.



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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 doesn't cover because it isn't 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 this *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



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- 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'll 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 don't want to be in the program, let us know, and we'll take you out of it.



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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.



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Chapter 6: What you pay for your Medicare and Medicaid prescription 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 Rx

Because you are eligible for Medicaid, 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/oh/mycare.
- **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 does not cover.
 - When you use the plan’s “Real Time Benefit Tool” to look up drug coverage (refer to **Chapter 5, Section B2**), the cost shown is 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*.
 - In most cases, you must use a network pharmacy to get your covered drugs. Network



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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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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 get 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 Medicaid. 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 is not part of our plan's benefit
- When you pay a copay for drugs that you get under a drug maker's patient assistance program
- When you buy covered drugs at an out-of-network pharmacy
- When you pay the full price for a covered drug 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 is complete and correct.

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

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 MyCare Ohio Full Dual 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- Call us at Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) Member Services.
- Or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- To report suspected Medicaid fraud in Ohio, you can:
 - Call the Ohio Department of Medicaid (ODM) at 614-466-0722.
 - Call the Medicaid Fraud Control Unit (MFCU) at 800-282-0515 www.ohioattorneygeneral.gov/About-AG/Service-Divisions/Health-Care-Fraud/Report-Medicaid-Fraud

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 a 90- or 100-day supply.

For details on where and how to get a long-term supply of a drug, refer to **Chapter 5** of your *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 *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.

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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Chapter 7: Asking us to pay our share of 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 MyCare Ohio Full Dual Advantage (HMO D-SNP) providers to bill you for these services or drugs. We pay our providers directly, and we protect you from any charges.

If you get a bill for health care or drugs, 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.
 - o If you paid for services covered by Medicare, we'll pay you back.
 - o If you paid for services covered by Medicaid we can't pay you back, but the provider will. Member Services or your care coordinator and/or ombudsperson, 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.
 - o If the provider should be paid, we'll pay the provider directly.
 - o 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



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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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.
 - o 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*).
 - o 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 within 1 year/365 days of the date you received 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 <https://shop.anthem.com/medicare>, or you can call Member Services and ask for the form.

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

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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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'll 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'll pay for it. If you already paid for the service or drug, we'll mail you a check for our share of the cost. If you paid the full cost of a drug, you might not be reimbursed the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid is higher than our negotiated price). If you haven't paid, we'll pay the provider directly.

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

- If we decide not to pay for the service or drug, we'll 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 this *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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 this *Member Handbook*.

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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 Spanish and in formats such as large print, braille, or audio. To get materials in one of these alternative formats, please call Member Services or write to: Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP), P.O. Box 105187, Atlanta, GA 30348-5187.
 - You can get this document for free in other languages and formats, such as large print, braille or audio. Call Member Services at the number listed on the bottom of this page. When calling, let us know if you want this to be a standing order. That means we will send the same documents in your requested format and language every year. You can also call us to change or cancel a standing order. You can also find your documents online at www.anthem.com/oh/mycare.

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.
- Ohio Medicaid consumer hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00pm and Saturday from 8:00 am to 5:00 pm. TTY users should call 711.
- Office for Civil Rights at 1-800-368-1019. TTY users should call 1-800-537-7697.

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

Debemos asegurarnos de que le proporcionen **todos** los servicios, tanto clínicos como no clínicos, de una manera culturalmente adecuada y accesible, incluso para aquellos con dominio limitado del inglés, habilidades de lectura limitadas, discapacidad auditiva u orígenes étnicos y culturales diversos. 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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- Para obtener información que pueda entender, llame a Servicio al Cliente. Nuestro plan tiene servicios de interpretación gratuitos disponibles para responder las preguntas en diferentes idiomas.
- Nuestro plan también puede brindarle materiales en idiomas, además del español, incluido el inglés y en formatos como letra grande, braille o audio. Para obtener materiales en uno de estos formatos alternativos, llame al Servicio al Cliente o escriba a Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP), P.O. Box 105187, Atlanta, GA 30348-5187.
 - o Puede recibir este documento de forma gratuita en otros idiomas y formatos, como en letra grande, braille o audio. Llame a Servicio al Cliente al número que figura en la parte inferior de esta página. Cuando llame, indique si se trata de un pedido regular. Eso quiere decir que 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 sus documentos en línea en anthem.com/oh/mycare.

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 a la línea directa para consumidores de Ohio Medicaid al 1-800-324-8680 de lunes a viernes de 7:00 a.m. a 8:00 p.m. y los sábados de 8:00 a.m. a 5:00 p.m. Los usuarios de TTY deben llamar al 711.
- La Oficina de Derechos Civiles al 1-800-368-1019. Los usuarios de TTY deben llamar al 1-800-537-7697.

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

You have rights as a member of our plan.

- You have the right to choose a primary care provider (PCP) in our network. A network provider is a provider who works with us. You can find more information about what types of providers may act as a PCP and how to choose a PCP in **Chapter 3** of this *Member Handbook*.
 - o Call your care coordinator or 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- o This includes the right to get timely services from specialists.
- o 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's 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 this *Member Handbook*.

Chapter 9 of this *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.

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 must release PHI by court order.
- 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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

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/oh/mycare 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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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

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.



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- 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:

- 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:



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- 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'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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.
- 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



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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.

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



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.
- 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 Spanish. We can also give you information in large print, braille, or audio.

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

- How to choose or change plans
- Our plan, including:



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- 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 care 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 this *Member Handbook*) and drugs (refer to **Chapters 5 and 6** of this *Member Handbook*) covered by our plan
 - o limits to your coverage and drugs
 - o rules you must follow to get covered services and drugs
- Why something isn't covered and what you can do about it (refer to **Chapter 9** of this *Member Handbook*), including asking us to:
 - o put in writing why something isn't 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 can't make you pay for covered services. They also can't 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 this *Member Handbook*.

F. Your right to leave our plan

No one can make you stay in our plan if you don't want to.

- You have the right to get most of your health care services through Original Medicare or another Medicare Advantage (MA) plan.



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- You can get your Medicare Part D drug benefits from a drug plan or from another MA plan.
- Refer to **Chapter 10** of this *Member Handbook*:
 - For more information about when you can join a new MA or drug benefit plan.
 - For information about how you'll get your Medicaid benefits if you leave our plan.

G. Your right to make decisions about your health care

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

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

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

- **Know your choices.** You have the right to be told about all treatment options.
- **Know the risks.** You have the right to be told about any risks involved. We must tell you in advance if any service or treatment is part of a research experiment. You have the right to refuse experimental treatments.
- **Get a second opinion.** You have the right to use another doctor before deciding on treatment.
- **Say no.** You have the right to refuse any treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to. You have the right to stop taking a prescribed drug. If you refuse treatment or stop taking a prescribed drug, we 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 this *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 can't make health care decisions for themselves. Before that happens to you, you can:



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- 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 **don't** want.

The legal document 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 aren't 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 social worker or some office supply stores. 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. Consider having a lawyer or someone else you trust, such as a family member or your PCP, help you complete it.
- **Give copies of the form to people who need to know.** 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 if you can't. You may want to give copies to close friends or family members. Keep a copy at home.
- If you're 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.
- The Designation of Authorized Representative form is available at www.dam.assets.ohio.gov/image/upload/medicaid.ohio.gov/Resources/Publications/Forms/ODM06723fillx.pdf. Call Member Services for more information on how to designate an authorized representative

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.



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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 Ohio Department of Health by calling 1-800-342-0553 or emailing HCComplaints@odh.ohio.gov.

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

Chapter 9 of this *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.

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 OSHIP program at 1-800-686-1578. For more details about OSHIP, refer to **Chapter 2**.
- Ohio Medicaid consumer hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users call 711.
- MyCare Ohio Ombudsman in the Office of the State Long-Term Care at 1-800-282-1206, Monday through Friday from 8:00 am to 5:00 pm. 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:



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- 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.
 - o 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.
 - o Ask any questions you have. Your doctors and other providers must explain things in a way you can understand. If you ask a question and you don't understand the answer, ask again.
- **Be considerate.** We expect all plan members to respect the rights of others. We also expect you to act with respect in your doctor's office, hospitals, and other provider offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
 - o Medicare Part A and Medicare Part B premiums. For most Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) members, Medicaid pays for your Medicare Part A premium and for your Medicare Part B premium.
 - o **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.
 - o **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* tells about our service area.
 - o 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.



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- Tell Medicare and Medicaid your new address when you move. Refer to **Chapter 2** of this *Member Handbook* for phone numbers for Medicare and Medicaid.
- **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.**
- **Learn more about estate recovery at** www.ssp.benefits.ohio.gov/apsspssp/pdf/ODM_07400.pdf



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

Introduction

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

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

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

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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 our plan

You can call our plan at 1-833-727-2169 to help deal with a problem or answer questions.

Help from the Ohio Senior Health Insurance Information Program (OSHIIP)

You can call the OSHIIP 1-800-686-1578. You can also review their website at <https://insurance.ohio.gov/consumers/medicare/01-oshiip>. OSHIIP counselors can answer your questions and help you understand what to do about your problem. OSHIIP isn't connected with us or with any



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insurance company or health plan. OSHIIP has trained counselors in every county, and services are free. The OSHIIP phone number is 1-800- 686-1578.

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 Ohio Medicaid

If you have questions about the help you get from Medicaid, call Ohio Medicaid Hotline 1-800-324-8680 Member Services: Monday through Friday 7 a.m. to 8 p.m. and Saturday 8 a.m. to 5 p.m. ET.

Help and information from MyCare Ohio Ombudsman

For more information and help, you can contact MyCare Ohio Ombudsman call 1-800-266-4346, Monday through Friday 8 a.m. to 5 p.m. For TTY, use Relay Ohio: Dial 711 and use 614-466-5500 for general information.

C. Understanding Medicare and Medicaid complaints and appeals in our plan

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

Sometimes Medicare and Medicaid processes can’t be combined. In those situations, you use one process for a Medicare benefit and another process for a Medicaid 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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 D1 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 Medicaid. 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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, **Section F2**, 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 a 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.

E3. Help with coverage decisions and appeals

You can ask for help from any of the following:

- **Member Services** at the numbers at the bottom of the page.
- Contact the Ohio Senior Health Insurance Information Program (OSHIIP) at 800-686-1578 (TTY: 711). Hours are Monday - Friday 7:30am - 5:00pm.
- **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.
 - 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.
- In addition to the member appeal, providers may also appeal to ODM's external medical review organization by accessing the “Ohio Medicaid MCE External Review Request” form located at www.gainwelltechnologies.com/permedion/ (listed under “Ohio Managed Care Entity External Medical Review”) and submit to the EMR entity together with the required supporting documentation. Providers must upload the request form and all supporting documentation to the EMR entity’s provider portal located at ecenter.hmsy.com (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access)



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.

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 our share of the cost of your care.

This section is about your benefits for medical care that is described in **Chapter 4** of this *Member Handbook*. 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**



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.

6. You're experiencing delays in care or you can't find a doctor.

What you can do: You can file a complaint. Refer to **Section K2**

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: 1-833-727-2169 (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:



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- **Seven calendar days** after we get your request **for a medical service or item does require prior authorization.**
- **Ten calendar days** after we get your request for all other medical services or items **that doesn't require prior authorization.**
- **48 hours** after we get your request **Medicare Part B drug.**

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

If you think we shouldn't take extra days, you can make a "fast complaint" about our decision to take extra days. When you make a fast complaint, we give you an answer to your complaint within 24 hours. The process for making a complaint is different from the process for coverage decisions and appeals. For more information about making a complaint, including a fast complaint, refer to Section K.

Fast coverage decision

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

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

- **72 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.**

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

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

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.
- Using the standard deadlines **could cause serious harm to your health** or hurt your ability to function.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

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 1-833-727-2169.

Ask for a standard appeal or a fast appeal in writing or by calling us at 1-833-727-2169.

- 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 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

- 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 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 have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- o If you meet this deadline, you'll get the service or item with no changes while your Level 1 appeal is pending.
- o You'll also get all other services or items (that aren't the subject of your appeal) with no changes.
- o 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 72 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.
 - o If we need extra days to make the decision, we tell you in writing.
 - o If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
 - o If we don't give you an answer within 72 hours or by the end of the extra days we took, we must send your request to Level 2 of the appeals process. An IRO then reviews it. The IRO will notify you in writing when it gets your appeal. Later in this chapter, we tell you about this organization and explain the Level 2 appeals process. If your problem is about coverage of a Medicaid service or item, you can file a Level 2 – Fair Hearing with the state yourself as soon as the time is up. In Ohio a Fair Hearing is called a 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.

There are deadlines for a standard appeal.

- When we use the standard deadlines, we must give you our answer **within 15 calendar days** after we get your appeal for coverage for services you didn't get.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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.
 - o If we need extra days to make the decision, we tell you in writing.
 - o If your request is for a Medicare Part B drug, we can't take extra time to make the decision.
 - o 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**.
 - o 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, 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. You can file a State Fair Hearing by contacting 866-635-3748, https://hearings.jfs.ohio.gov/apps/SHARE/#_frmHomeScreen.

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 Medicaid 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, Medicaid, or both programs usually cover the service or item.

- If your problem is about a service or item that **Medicare** usually covers, we automatically send your case to Level 2 of the appeals process as soon as the Level 1 Appeal is complete.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

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

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

- If your problem is about a service usually covered only by Medicare, your benefits for that service don't continue during the Level 2 appeals process with the IRO.
- If your problem is about a service usually covered only by Medicaid, 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 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 you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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.

If 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, :**
 - 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.

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

A Level 2 Appeal for services that Medicaid usually covers is a Fair Hearing with the state. You must ask for a Fair Hearing in writing or by phone **within 90 calendar days** of the date we sent the decision letter



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on your Level 1 Appeal. The letter you get from us tells you where to submit your request for a Fair Hearing.

A state hearing is a meeting with you or your authorized representative, someone from the County Department of Job and Family Services, someone from our plan, and a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services (ODJFS). In this meeting, you will explain why you think our plan did not make the right decision and our plan will explain the reasons for making our decision. The hearing officer will listen and then make a decision based on the rules and the information given by you and our plan.

Our plan will notify you of your right to request a state hearing if we do not change our decision or action as a result of your appeal. If you want a state hearing, you or your authorized representative must request a hearing within 90 calendar days. The 90-calendar day period begins on the day after the mailing date on the hearing form. If your appeal was about a decision to reduce, suspend, or stop services before you get all the approved services, your letter will tell you how you can keep getting the services if you choose to and when you may have to pay for the services. You may only request a state hearing after you have gone through our plan appeal process.

To request a hearing, you can:

- Sign and return the state hearing form to the address or fax number listed on the form.
- Call the Bureau of State Hearings at 866-635-3748.
- Submit your request online at https://hearings.jfs.ohio.gov/apps/share/#_frmlogin.
- Submit your request via e-mail at bsh@jfs.ohio.gov.

If you want information on free legal services but don't know the number of your local legal aid office, you can call the Ohio State Legal Services Association at 1-800-589-5888. State hearing decisions are usually issued no later than 70 calendar days after the request is received. However, if the Bureau of State Hearings decides that the health condition meets the criteria for an expedited decision, the decision will be issued as quickly as needed but no later than three working days after the request is received. Expedited decisions are for situations when making the decision within the standard time frame could seriously jeopardize your life or health or ability to attain, maintain, or regain maximum function.

The Fair Hearing office gives you their decision in writing and explains the reasons.

- If the Fair Hearing office says **Yes** to part or all of a request for a medical item or service, we must authorize or provide the service or item **within 72 hours** after we get their decision.
- If the Fair Hearing office says **No** to part or all of your appeal, it means they agree that we 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 you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

If the IRO or Fair Hearing office decision is No for all or part of your request, you have additional appeal rights.

If your Level 2 Appeal went to the IRO, you can appeal again only if the dollar value of the service or item you want meets a certain minimum amount. An ALJ or attorney adjudicator handles a Level 3 Appeal. The letter you get from the IRO explains additional appeal rights you may have.

The letter you get from the Fair Hearing office describes the next appeal option.

Refer to Section J for more information about your appeal rights after Level 2.

In addition to the member appeal, providers may also appeal to ODM's external medical review organization by accessing the "Ohio Medicaid MCE External Review Request" form located at www.gainwelltechnologies.com/permedion/ (listed under "Ohio Managed Care Entity External Medical Review") and submit to the EMR entity together with the required supporting documentation. Providers must upload the request form and all supporting documentation to the EMR entity's provider portal located at ecenter.hmsy.com/ (new users will send their documentation through secured email at IMR@gainwelltechnologies.com to establish portal access)

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 you get a bill that's more than your copay for covered services and items, send the bill to us. Don't pay the bill yourself. We'll contact the provider directly and take care of the problem. If you do pay the bill, you can get a refund from our plan if you followed the rules for getting services or item.

For more information, refer to Chapter 7 of this Member Handbook. It describes situations when you may need to ask us to pay you back or pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

If you ask to be paid back, you're asking for a coverage decision. We'll check if the service or item you paid for is covered and if you followed all the rules for using your coverage.

- If the service or item you paid for is covered and you followed all the rules, we'll send you the payment or if the plan has cost-sharing, our share of the cost for the service or item typically within 30 calendar days, but no later than 60 calendar days after we get your request.
- 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 you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 15 calendar days after we get your appeal.

If our answer to your appeal is **No** and **Medicare** usually covers the service or item, we'll 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 Medicaid usually covers the service or item, you can file a Level 2 Appeal yourself. Refer to Section F4 for more information. You can file the hearing at hearings.jfs.ohio.gov/apps/SHARE/#_frmHomeScreen. Please email BSH@jfs.ohio.gov or call 866-635-3748.

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 Medicaid 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:
 - cover a Medicare Part D drug that isn't on our plan's Drug List or



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- 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 Drug List or need us to set aside a rule or restriction on a drug we cover.	You want us to cover a drug on our Drug List, and you think you meet plan rules or restrictions (such as getting approval in advance) for the drug you need.	You want to ask us to pay you back for a drug you already got and paid for.	We told you that we won’t cover or pay for a drug in the way that you want.
You can ask us to make an exception. (This is a type of coverage decision.)	You can ask us for a coverage decision.	You can ask us to pay you back. (This is a type of coverage decision.)	You can make an appeal. (This means you ask us to reconsider.)
Start with Section G2 , then refer to Sections G3 and G4.	Refer to Section G4.	Refer to Section G4.	Refer to Section G5.

G2. Medicare Part D exceptions

If we don’t cover a drug in the way you would like, you can ask us to make an “exception.” If we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber needs to explain the medical reasons why you need the exception.

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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

- You can't get an exception to the required copay amount for the drug.

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 this *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.
- Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs.

G3. Important things to know about asking for an exception

Your doctor or other prescriber must tell us the medical reasons.

Your doctor or other prescriber must give us a statement explaining the medical reasons for asking for an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Our Drug List often includes more than one drug for treating a specific condition. These are called “alternative” drugs. If an alternative drug is just as effective as the drug you ask for and wouldn't cause more side effects or other health problems, we generally do **not** approve your exception request.

We can say Yes or No to your request.

- If we say **Yes** to your exception request, the exception usually lasts until the end of the calendar year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.



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- 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 1-833-293-0661, 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 this *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're 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 1-833-727-2169, 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 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:

- We must provide the approved drug coverage within 72 hours after we get the IRO’s decision.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 Level 3 Appeals. Refer to Section J for information about Level 3, 4, and 5 Appeals.

H. Asking us to cover a longer hospital stay

When you're admitted to a hospital, you have the right to get all hospital services that we cover that are necessary to diagnose and treat your illness or injury. For more information about our plan's hospital coverage, refer to **Chapter 4** of 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 are concerned about your care after you leave the hospital, you can ask for a longer hospital stay. This section tells you how to ask.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 **doesn't** 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 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Ohio, the QIO is Commence Health Livanta. Call them at 1-888-524-9900, or TTY 1-888-985-8775. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. You can also write to 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701. Our website is Commence Health BFCC-QIO - Ohio. 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 don’t 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 Health Insurance Counseling and Advocacy Program (HICAP) at 1-800-686-1578.

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’s 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/formsnotices/beneficiary-notices-initiative/ffs-ma-im.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.

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 our share of hospital care costs since noon on the day after the date the QIO turned down your Level 1 Appeal.
- We will provide your covered inpatient hospital services for as long as the services are medically necessary.

If the QIO says **No** to your appeal:

- They agree with their decision about your Level 1 Appeal and won't change it.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- o Call Member Services at the numbers at the bottom of the page.
- o Call the OSHIIP at 1-800-686-1578.
- **Contact the QIO.**
 - o Refer to **Section H2** or refer to **Chapter 2** of this *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:

- Your coverage ends on the date we told you.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- We stop paying the costs of this care on the date in the notice.
- You pay the full cost of this care yourself if you decide to continue the home health care, skilled nursing facility care, or CORF services after the date your coverage ends
- You decide if you want to continue these services and make a Level 2 Appeal.

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 Commence Health at 1-888-524-9900, TTY 1-888-985-8775. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. You can also write to 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701. Our website is www.commencehealthqio.cms.gov/en/states/ohio.

You must ask for this review **within 60 calendar days** after the day the QIO said **No** to your Level 1 Appeal. You can ask for this review **only** if you continue care after the date that your coverage for the care ended.

QIO reviewers will:

- Take another careful look at all of the information related to your appeal.
- Tell you their decision about your Level 2 Appeal within 14 calendar days of receipt of your request for a second review.

If the QIO says **Yes** to your appeal:

- We pay you back for the costs of care you got since the date when we said your coverage would end.
- We'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.
- You may file a complaint with and ask the DMHC for an Independent Medical Review to continue coverage of your health care services. Please refer to **Section F4** on page 200 to learn how to ask the DMHC for an Independent Medical Review. You can file a complaint with and ask the DMHC for an Independent Medical Review in addition to or instead of 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

J. Taking your appeal beyond Level 2

J1. Next steps for Medicare services and items

If you made a Level 1 Appeal and a Level 2 Appeal for Medicare services or items, and both of your appeals were turned down, you may have the right to additional levels of appeal.

If the dollar value of the Medicare service or item you appealed does not meet a certain minimum dollar amount, you cannot appeal any further. If the dollar value is high enough, you can continue the appeals process. The letter you get from the IRO for your Level 2 Appeal explains who to contact and what to do to ask for a Level 3 Appeal.

Level 3 Appeal

Level 3 of the appeals process is an ALJ hearing. The person who makes the decision is an ALJ or an attorney adjudicator who works for the federal government.

If the ALJ or attorney adjudicator says **Yes** to your appeal, we have the right to appeal a Level 3 decision that's 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'll 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 you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

If the Council says **No** or denies our review request, the appeals process may not be over.

- If you decide **to accept** this decision that turns down your appeal, the appeals process is over.
- If you decide **not to accept** this decision that turns down your appeal, you may be able to continue to the next level of the review process. The notice you get will tell you if you can go on to a Level 5 Appeal and what to do.

Level 5 Appeal

- A Federal District Court judge will review your appeal and all of the information and decide **Yes** or **No**. This is the final decision. There are no other appeal levels beyond the Federal District Court.

J2. Additional Medicaid appeals

You also have other appeal rights if your appeal is about services or items that Medicaid usually covers. The letter you get from the Fair Hearing office will tell you what to do if you want to continue the appeals process. Next level appeal is called an administrative appeal and is conducted by the Bureau of State Hearings (Hearings Supervisors) if a person disagrees with the outcome of the state hearing. If they wish to appeal beyond the administrative appeal, the next level is called judicial review and is appealed through the court of common pleas in their residential county.

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 have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- If you decide **not to accept** this decision that turns down your appeal, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 Appeal.

Level 4 Appeal

The Council reviews your appeal and gives you an answer. The Council is part of the federal government.

If the Council says **Yes** to your appeal:

- The appeals process is over.
- We must authorize or provide the approved drug coverage within 72 hours (or 24 hours for an expedited appeal) or make payment no later than 30 calendar days after we get the decision.

If the Council says **No** to your appeal 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 Member Services. 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Complaint	Example
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're being pushed out of our plan.
Accessibility and language assistance	• You can't 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 doesn't give you other reasonable accommodations you need and ask for.
Waiting times	• You have trouble getting an appointment or wait too long to get it. • Doctors, pharmacists, or other health professionals, Member Services, or other plan staff keep you waiting too long.
Cleanliness	• You think the clinic, hospital or doctor's office 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.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 1-833-727-2169.

The legal term for “complaint” is “**grievance.**”

The legal term for “making a complaint” is “**filing a grievance.**”

K2. Internal complaints

To make an internal complaint, call Member Services at 1-833-727-2169. You can make the complaint at any time unless it is about a Medicare Part D drug. If the complaint is about a Medicare Part D drug, you must make it within **60 calendar days** after you had the problem you want to complain about.

- If there'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.
- If you contact us because you are unhappy with something about Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) or one of our providers, this is called a grievance. Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) will give you an answer to your grievance by phone (or by mail if we can't reach you by phone) within the following time frames:
 - o Two working days for grievances about not being able to get medical care
 - o Thirty calendar days for all other grievances

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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

K3. External complaints

Medicare

You can tell Medicare about your complaint or send it to Medicare. The Medicare Complaint Form is available at: . You don't need to file a complaint with Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) before filing a complaint with Medicare.

Medicare takes your complaints seriously and uses this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the health plan isn't 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.

You can tell Medicaid about your complaint. You can call the Ohio Medicaid Consumer Hotline at 1-800-324-8680 or TTY 711. The call is free. You can also e-mail your complaint to bmhc@medicaid.ohio.gov.

Office for Civil Rights (OCR)

You can make a complaint to the Department of Health and Human Services (HHS) OCR if you think you haven't 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
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019,; 1-800-537-7697 (TDD)

You may also have rights under the Americans with Disability Act (ADA). You can contact Member Services at 1-833-727-2169 or the Ohio Medicaid Consumer Hotline at 1-800-324-8680 (TTY: 711) for assistance or odm_eeo_employeerelations@medicaid.ohio.gov.

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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Ohio, the QIO is called Commence Health. The phone number for Commence Health is 1-888-524-9900 or TTY 1-888-985-8775. This number is for people who have hearing or speaking problems. You must have special telephone equipment to call it. You can also write to 10820 Guilford Rd., Suite 202 Annapolis Junction, MD 20701. Our website is www.commencehealthqio.cms.gov/en/states/ohio.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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'll still be in the Medicare and Medicaid programs as long as you're eligible. 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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Medicaid, you have some choices to end your membership with our plan including any month of the year. Since Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) covers both Medicare and Medicaid services, your Medicaid coverage is aligned to match your selected Medicare plan. As long as you're enrolled in this Medicare plan for your Medicare benefits, your Medicaid enrollment will be with Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) plan as well.

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 Medicaid or Extra Help changed, **or**
- if you recently moved into, currently getting care in, or just moved out of a nursing facility or a long-term care hospital.

Your **Medicare** membership ends on the last day of the month that we get your request to leave your 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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- The State Health Insurance Assistance Program (SHIP), Ohio Senior Health Insurance Information Program (OSHIIP) at (800) 686-1578. TTY users should call 1-614-644-3264.

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 have not 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 on page 229.
- Call Ohio Medicaid at 1-800-324-8680 (TTY: 711), 7 a.m. – 8 p.m. Monday – Friday, Saturday 8 a.m. to 5 p.m. Section C below includes steps that you can take to enroll in a different plan, which will also end your membership in our plan.

C. How to get Medicare and Medicaid 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 MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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, call 1-855-921-PACE (7223). If you need help or more information: • Call the Ohio Senior Health Insurance Information Program (OSHIIP) at (800) 686-1578 or email oshiipmail@insurance.ohio.gov Monday - Friday 7:30 a.m. - 5 p.m. For more information or to find a local OSHIIP office in your area, please visit www.insurance.ohio.gov/consumers/medicare/01-oshiip. OR Enroll in a new integrated D-SNP. You'll automatically be disenrolled from our Medicare plan when your new plan's coverage begins. Switching to Original Medicare won't affect your Ohio Medicaid enrollment. Ohio Medicaid will automatically align your Medicaid enrollment to match your plan selection.
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If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Ohio Senior Health Insurance Information Program (OSHIIP) at (800) 686-1578 or email oshiipmail@insurance.ohio.gov Monday - Friday 7:30 a.m. - 5 p.m. For more information or to find a local OSHIIP office in your area, please visit www.insurance.ohio.gov/consumers/medicare/01-oshiip. OR Enroll in a new Medicare drug plan. You'll automatically be disenrolled from our plan when your Original Medicare coverage begins. Switching to Original Medicare won't affect your Ohio Medicaid enrollment. If you need help or more information: - Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 5 p.m. TTY users should call the Ohio Relay Service at 7-1-1.
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If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Ohio Senior Health Insurance Information Program (OSHIIIP) at 1-800-686-1578, Monday through Friday from 7:30 a.m. to 5:00 p.m. or email oshiipmail@insurance.ohio.gov. For more information or to find a local Ohio Senior Health Insurance Information Program (OSHIIIP) in your area, please visit www.insurance.ohio.gov/consumers/medicare/01-oshiip.

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 Ohio Senior Health Insurance Information Program (OSHIIIP) at (800) 686-1578 or email oshiipmail@insurance.ohio.gov Monday - Friday 7:30 a.m. - 5 p.m. For more information or to find a local OSHIIIP office in your area, please visit www.insurance.ohio.gov/consumers/medicare/01-oshiip.

You'll automatically be disenrolled from our plan when your Original Medicare coverage begins.

If you need help or more information:

- Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 5 p.m. TTY users should call the Ohio Relay Service at 7-1-1.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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. For Program of All-Inclusive Care for the Elderly (PACE) inquiries, call 1-855-921-PACE (7223). If you need help or more information: - Call the Ohio Senior Health Insurance Information Program (OSHIIP) at (800) 686-1578 or email oshiipmail@insurance.ohio.gov Monday - Friday 7:30 a.m. - 5 p.m. For more information or to find a local OSHIIP office in your area, please visit www.insurance.ohio.gov/consumers/medicare/01-oshiip. 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 need help or more information: Your Medicaid won't be affected by switching Medicare plans, unless you're choosing a PACE program. If you choose PACE coverage, then your Medicaid will be covered through PACE. - Call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7 a.m. to 8 p.m. and Saturday from 8 a.m. to 5 p.m. TTY users should call the Ohio Relay Service at 7-1-1.
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C2. Your Medicaid services

You must get your benefits from a MyCare Ohio plan unless you:

- Are enrolled in the Program of All-inclusive Care for the Elderly (PACE).



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

- Have other third-party creditable health care coverage (other than Medicare).
- Are a member of a federally recognized Indian tribe.

You may choose a different MyCare plan. If you choose a different MyCare plan to manage your Medicare benefits, the Ohio Department of Medicaid will align your Medicaid coverage to match your Medicare selection. If you choose traditional Medicare or another Medicare Advantage plan other than a MyCare plan, you can still choose a different MyCare plan to manage your Medicaid benefit. If you don't choose a different MyCare plan, you'll remain in our plan to receive your Medicaid services.

Your Medicaid services include most long-term services and supports and behavioral health care. For more information on supplemental services see **Chapter 4, Section E**.

If you stop getting Medicare services through our plan, you'll get a new Member ID Card and a new *Member Handbook* for your Medicaid services.

If you want to switch to a different MyCare Ohio plan to get your Medicaid benefits, call the Ohio Medicaid Consumer Hotline at 1-800-324-8680, Monday through Friday from 7:00 am to 8:00 pm and Saturday from 8:00 am to 5:00 pm. TTY users should call the Ohio Relay Service at 7-1-1. The Ohio Medicaid Consumer Hotline can't change your Medicare enrollment—only your Medicaid. To change your Medicare enrollment, follow the process described in **Section C1**.

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 Medicaid 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 MyCare Ohio Full Dual 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.



If you have questions, please call Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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.
- Note: If you no longer qualify for Medicaid, you can temporarily continue in our plan with Medicare benefits, please see information below on deeming period.
- 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 lose your Ohio Medicaid eligibility but can be expected to regain it within six months, we'll continue to provide all Medicare benefits covered by Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP). When your Ohio Medicaid coverage ends, we won't pay for your Ohio Medicaid 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 Ohio Medicaid eligibility or Extra Help, your cost for covered Part D prescription drugs may increase.

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

We'll assist you to regain your Ohio Medicaid eligibility. If your Ohio Medicaid 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 Ohio Medicaid benefits and your Medicare premiums,



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Ohio Medicaid within six months we'll disenroll you from Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP). If you regain Ohio Medicaid 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 can't 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.

G. Your right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also refer to **Chapter 9** of this *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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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 Medicaid programs. Other federal and state laws may apply too.

B. Notice about nondiscrimination

We don't discriminate or treat you differently because of your race, ethnicity, national origin, color, religion, sex, 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. Ohio Department of Job and Family Services at 1-866-227-6353 (TTY:711)
- 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 Medicaid 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 Medicaid is the payer of last resort.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

Chapter 12: Definitions of important words

Introduction

This chapter includes key terms used throughout this *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 | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information**, visit www.anthem.com/oh/mycare.

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. Refer to Chapter 9, Section F4 for more information.

AIDS drug assistance program (ADAP): A program that helps eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Refer to Chapter 2, Section H2 for more information.

Ambulatory surgical center: A facility that provides outpatient surgery to patients who don't need hospital care and who aren't 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 this *Member Handbook* explains appeals, including how to make an appeal.

Behavioral health: An all-inclusive term referring to mental health and substance use disorders.

Biological product: A drug that's made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (See also "Original biological product" and "Biosimilar").

Biosimilar: A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription. (Go to "Interchangeable biosimilar").

Brand name drug: A drug that's 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 and are generally not available until the patent on the brand name drug has ended. Refer to Chapter 5, Section B1 for more information.

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. Refer to Chapter 3, Section C for more information.

Care plan: Refer to "Individualized care plan."

Care team: Refer to "Interdisciplinary care team."

Catastrophic coverage stage: The stage in the Medicare Part D drug benefit where our plan pays all costs of your drugs until the end of the year. You begin this stage when you (or other qualified parties on your behalf) have spent \$2,400 for Part D covered drugs during the year. Refer to Chapter 6, Section E for more information.

Centers for Medicare & Medicaid Services (CMS): The federal agency in charge of Medicare. **Chapter 2** of this *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



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

network providers, or our network pharmacies. The formal name for “making a complaint” is “filing a grievance”. Refer to Chapter 9 for more information.

Comprehensive outpatient rehabilitation facility (CORF): A facility that mainly provides rehabilitation services after an illness, accident, or major operation. It provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy, speech therapy, and home environment evaluation services. Refer to Chapter 9, Section I for more information.

Copay: A fixed amount you pay as your share of the cost each time you get certain drugs. For example, you might pay \$2 or \$5 for a drug. Refer to Chapter 4 and Chapter 6 for more information.

Cost-sharing: Amounts you have to pay when you get certain drugs. Cost-sharing includes copays. Refer to Chapter 4 and Chapter 6 for more information.

Cost-sharing tier: A group of drugs with the same copay. Every drug on the *List of Covered Drugs* (also known as the Drug List) is in one of 5 cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. Refer to Chapter 6 for more information.

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 this *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. Refer to Chapter 6 for more information.

Covered services: The general term we use to mean all the health care, long-term services and supports, supplies, prescription and over-the-counter drugs, equipment, and other services our plan covers. Refer to Chapter 4 for more information.

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. Refer to Chapter 8, Section A for more information.

Daily cost-sharing rate: A rate that may apply when your doctor prescribes less than a full month’s supply of certain drugs for you and you’re required to pay a copay. A daily cost-sharing rate is the copay divided by the number of days in a month’s supply.

Here is an example: Let’s say the copay for your drug for a full month’s supply (a 30-day supply) is \$1.35. This means that the amount you pay for your drug is less than \$0.05 per day. If you get a seven-day supply of the drug, your payment is less than \$0.05 per day multiplied by seven days, for a total payment less than \$0.35.

Disenrollment: The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Refer to Chapter 10, Section B for more information.

Drug management program (DMP): A program that helps make sure members safely use prescription opioids and other frequently abused medications. Refer to Chapter 5, Section G3 for more information.



If you have questions, please call Anthem | MyCare Ohio Full Dual Advantage (HMO D-SNP) at 1-833-727-2169 (TTY: 711). Hours are from 8 a.m. to 8 p.m., seven days a week (except Thanksgiving and Christmas) from October 1 through March 31, and Monday to Friday (except holidays) from April 1 through September 30. The call is free. **For more information,** visit www.anthem.com/oh/mycare.

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 5 tiers. Refer to Chapter 6 for more information.

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. Refer to Chapter 3 and Chapter 4 for more information.

Emergency: A medical emergency when you, or any other person with an average knowledge of health and medicine, believe that you have medical symptoms that need immediate medical attention to prevent death, loss of a body part, or loss of or serious impairment to a bodily function (and if you're a pregnant woman, loss of an unborn child). The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Refer to Chapter 3, Section I for more information.

Emergency care: Covered services given by a provider trained to give emergency services and needed to treat a medical or behavioral health emergency. Refer to Chapter 3, Section I for more information.

Exception: Permission to get coverage for a drug not normally covered or to use the drug without certain rules and limitations. Refer to Chapter 9 for more information.

Excluded Services: Services that aren't covered by this health plan. Refer to Chapter 9, Section G for more information.

Extra Help: 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". Refer to Chapter 2, Section H for more information.

Generic drug: A drug approved by the FDA 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. Refer to Chapter 5, Section B1 for more information.

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. Refer to Chapter 9 for more information.

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. Refer to Chapter 1 for more information.

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. Refer to Chapter 1, Section A for more information.



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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. Refer to Chapter 1, Section J2 for more information.

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. Refer to Chapter 4, Section D for more information.

- 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 isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work. The formal name is the **Independent Review Entity**. Refer to Chapter 5, Section G3 for more information.

Individualized care plan (ICP or Care plan): A plan for what services you'll get and how you'll get them. Your plan may include medical services, behavioral health services, and long-term services and supports.

Initial coverage stage: The stage before your total Medicare Part D drug expenses reach \$2,400. This includes amounts you paid, what our plan paid on your behalf, and the low-income subsidy. You begin in this stage when you fill your first prescription of the year. During this stage, we pay part of the costs of your drugs, and you pay your share. Refer to Chapter 6, Section D for more information.

Inpatient: A term used when you're 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. Refer to Chapter 4, Section D for more information.

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. Refer to Chapter 10, Section C1 for more information.

Interchangeable Biosimilar: A biosimilar that may be substituted at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic



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substitution. Automatic substitution at the pharmacy is subject to state law. Refer to Chapter 5, Section B1 for more information.

Interdisciplinary care team (ICT or Care team): A care team may include doctors, nurses, counselors, or other health professionals who are there to help you get the care you need. Your care team also helps you make a care plan.

List of Covered Drugs (Drug List): A list of prescription and over-the-counter (OTC) drugs we cover. We choose the drugs on this list with the help of doctors and pharmacists. The *Drug List* tells you if there are any rules you need to follow to get your drugs. The *Drug List* is sometimes called a “formulary”. Refer to Chapter 1, Section J3 for more information.

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 and Nursing Facilities (NF).

Low-income subsidy (LIS): Refer to “Extra Help”

Medicaid: This is the name of Ohio Medicaid program. Medicaid 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, behavioral health and other medical costs.

- It covers extra services and some drugs not covered by Medicare.
- Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medicaid (or Medical Assistance): A program run by the federal government and the state that helps people with limited incomes and resources pay for long-term services and supports and medical costs. Refer to Chapter 1, Section B1 or Chapter 2, Section F for more information.

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”). Refer to Chapter 2, Section E for more information.

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. Refer to Chapter 2, Section H3 for more information.

Medicare Appeals Council (Council): A council that reviews a level 4 appeal. The Council is part of the Federal government. Refer to Chapter 9, Section J1 for more information.



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Medicare-covered services: Services covered by Medicare Part A and Medicare Part B. All Medicare health plans, including our plan, must cover all 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. Refer to Chapter 4, Section D for more information.

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 drug benefit program. We call this program “Part D” for short. Medicare Part D covers outpatient 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 Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program MTM services usually include a discussion with a pharmacist or health care provider to review medications. Refer to Chapter 5 of this *Member Handbook* for more information.

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

Member 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 this *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



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your prescriptions only when filled at one of our network pharmacies. Refer to Chapter 1, Section J2 for more information.

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're 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 don't 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”.

Refer to Chapter 1, Section J2 for more information.

Nursing home or facility: A place that provides care for people who can't get their care at home but don't need to be in the hospital.

Ombudsperson: An office in your state that works as an advocate on your behalf. They can answer questions if you have a problem or complaint and can help you understand what to do. The ombudsperson's services are free. You can find more information in **Chapters 2 and 9** of this *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 this *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.

- 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 hasn't 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. Refer to Chapter 5, Section A8 for more information.



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Out-of-network provider or **Out-of-network facility:** A provider or facility that isn't employed, owned, or operated by our plan and isn't under contract to provide covered services to members of our plan.

Chapter 3 of this *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. Refer to Chapter 6, Section A for more information.

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. Refer to Chapter 8, Section C for more information.

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). Refer to Chapter 4 for more information.

Primary care provider (PCP): The doctor or other provider you use first for most health problems. They make sure you get the care you need to stay healthy.

- They also may talk with other doctors and health care providers about your care and refer you to them.
- In many Medicare health plans, you must use your primary care provider before you use any other health care provider.
- Refer to **Chapter 3** of this *Member Handbook* for information about getting care from primary care providers.

Prior authorization (PA): An approval you must get from us before you can get a specific service or drug or use an out-of-network provider. Our plan may not cover the service or drug if you don't get approval first.

Our plan covers some network medical services only if your doctor or other network provider gets PA from us.

- Covered services that need our plan's PA are marked in **Chapter 4** of this *Member Handbook*.



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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*.

and the rules are posted on our website.

Program of 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. Refer to Chapter 2 for more information.

Prosthetics and Orthotics: Medical devices ordered by your doctor or other health care provider that include, but aren't 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. Refer to Chapter 4 for more information.

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 this *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. Refer to Chapter 5, Section C for more information.

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. Refer to Chapter 5, Section B2 for more information.

Referral: A referral is your primary care provider's (PCP's) approval to use a provider other than your PCP. If you don't get approval first, we may not cover the services. You don't need a referral to use certain specialists, such as women's health specialists. You can find more information about referrals in **Chapters 3 and 4** of 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.

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. Refer to Chapter 1, Section D for more information.

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. Refer to Chapter 6, Section E for more information.



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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. Refer to Chapter 3, Section K for more information.

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. Refer to Chapter 3, Section K for more information.

Specialist: A doctor who provides health care for a specific disease or part of the body.

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. Refer to Chapter 5, Section C for more information.

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 aren't the same as Social Security benefits.

Urgently needed care: Care you get for an unforeseen illness, injury, or condition that isn't an emergency but needs care right away. You can get urgently needed care from out-of-network providers when you can't get to them because given your time, place, or circumstances, it isn't possible, or it's unreasonable to obtain services from network providers (for example when you're outside our plan's service area and you require medically needed immediate services for an unseen condition but it isn't a medical emergency). Refer to Chapter 3, Section I2 for more information.



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Anthem I MyCare Ohio Full Dual Advantage (HMO D-SNP) Member Services

CALL	1-833-727-2169 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/oh/mycare

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