

The Provost's Office, together with Human Resources, has developed the following Frequently Asked Questions (FAQs) regarding the recent changes to the Retiree Medical Plan for Medicare-eligible participants, which went into effect January 1, 2019. We will work with Anthem to continue to update and augment the FAQs, incorporating additional information and new questions as they arise.

For additional information about the Retiree Medical Plan, or if you have specific issues you'd like to discuss, please contact:

Xaviera Espinoza, 1-773-702-4026 / xaviera@uchicago.edu

University of Chicago Benefits Office: 1-855-822-8901 / retiree@uchicago.edu

You are also welcome and encouraged to share your experiences with the Provost's Office at emeritifaculty@uchicago.edu

Please note: This document is intended to provide general information regarding the Retiree Medical Plan for its Medicare-eligible population. In the event of a discrepancy between this document and the legal plan document, which governs the operation of the Retiree Medical Plan, the Plan document will take precedence. Please contact the Benefits Office (xaviera@uchicago.edu) for a copy of the Plan document.

FAQs - 2019 Retiree Medical Plan

Beginning in late October 2018, Medicare-eligible members of the Retiree Medical Plan were mailed the following documents. Links are provided in blue beneath each listed document:

2019 Retiree Medical Plan Guide (including a cover letter) on 10/24/18:

[Link to Guide](#)

[Link to Cover Letter](#)

Welcome Kit (including a new ID card) on 12/21/18:

[Link to Welcome Kit](#)

Evidence of Coverage document on 1/3/19:

[Link to Evidence of Coverage](#)

If you believe you did not receive these documents or are unable to locate them, you can use the links above to download them again or contact xaviera@uchicago.edu for assistance.

Key Contacts

Xaviera Espinoza: 1-773-702-4026 / xaviera@uchicago.edu

University of Chicago Benefits Office: 1-855-822-8901 / retiree@uchicago.edu

Anthem Blue Cross Blue Shield Member Services: 1-833-214-8952

Anthem Nurse HelpLine: 1-800-700-9184

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General Questions about the Retiree Medical Plan for Members Age 65 & Over

(1) I am over 65 and covered by the Retiree Medical Plan. What is my insurance coverage for 2019?

If you and/or your covered dependents are age 65 or over and enrolled in Medicare, your insurance coverage is afforded by the *Anthem Medicare Preferred (PPO)* plan administered by Anthem Inc., and uses the Blue Medicare Advantage PPO network of doctors and hospitals. The Anthem Medicare Preferred PPO is what Medicare calls a “Medicare Advantage Plan” (see question 2). The coverage offered under your plan abides by Medicare coverage guidelines and includes “National Access Plus,” which allows you to see any doctor who accepts Medicare, regardless of whether they are in-network or out-of-network under the Anthem Medicare Preferred (PPO).

Please note that while out-of-network providers are not obligated to treat you, except in emergency situations, many will in fact provide routine treatment, and your co-insurance and co-pays for the plan are the same for both in and out-of-network providers. Anthem does suggest that you seek a pre-visit coverage determination before seeing an out-of-network provider; for a decision about whether the Anthem Medicare Preferred PPO will cover an out-of-network service or provider, you are encouraged to contact Anthem for a pre-visit coverage decision or you may contact the provider directly who may initiate this process on your behalf. Xaviera Espinoza in the University Benefits Office is also available to assist plan members in this regard by reaching out to specific providers and, when necessary, reaching out to Anthem as well. As of May 17, 2019, Anthem has approved 97.8% of prior authorization requests (including pre-visit coverage decisions) for both in- and out-of-network providers.

If you and/or your covered dependents are under 65 and not eligible for Medicare, or if you are living outside of the United States, your insurance coverage is afforded by a Preferred Provider Organization (PPO) plan administered by Blue Cross Blue Shield of Illinois (BCBSIL) (“BCBSIL PPO”), which uses the BCBSIL network of doctors and hospitals. The BCBSIL PPO is not a Medicare Advantage plan.

(2) Is a “Medicare Advantage Plan” the same as having Medicare?

A Medicare Advantage Plan is a plan offered by a private company that is approved by Medicare. Medicare Advantage Plans are also sometimes called “Medicare Part C” because they include both Medicare Part A (hospital insurance) and Part B (medical insurance). Coverage under a Medicare Advantage Plan means you still have Medicare, but your insurance coverage is managed and paid for by the Medicare-approved private company—in this case, Anthem.

With the Anthem Medicare Preferred PPO, you no longer interact with Medicare for coordination of benefits. Rather, Anthem coordinates directly with your providers and Medicare. If you have the Anthem Medicare Preferred PPO through the Retiree Medical Plan, you are still part of the federal Medicare program. Your medical services must be provided by a doctor who accepts Medicare, even though Medicare pays Anthem for your care instead of paying your doctor directly. The plan also offers benefits beyond traditional Medicare coverage, including routine hearing services, hearing aid coverage, membership in the SilverSneakers fitness program, and vision discounts.



(3) What if I am 65 or over and Medicare-eligible, but my covered dependent is under 65 (or vice versa), and we're both enrolled in the Retiree Medical Plan?

You and your eligible dependents may be enrolled in different medical plans based on your Medicare eligibility. For 2019, the family member who is eligible for Medicare will be covered by the Anthem Medicare Preferred PPO and the family member who is not eligible for Medicare will be covered by the current BCBSIL PPO.

(4) How is prescription drug coverage affected as a result of the transition to the Anthem Medicare Preferred PPO?

Your Medicare Part D prescription drug program continues to be administered by Express Scripts. The Anthem Medicare Preferred PPO does not include Medicare Part D prescription drug coverage. For information on your prescriptions, or to find an Express Scripts participating retail network pharmacy in your area, visit express-scripts.com. You can also call Express Scripts Customer Service at 1-866-838-3979 (age 65 or over) or 1-800-935-7189 (under age 65).

(5) I'm not familiar with some of the terms used in the Anthem Medicare Preferred PPO documents I received. How do I find out more?

Please see the [Glossary of Terms](#) at the end of this FAQ for definitions of common terms. If you are 65 or over and enrolled in Medicare, there are additional definitions included in your Anthem Blue Cross Blue Shield [Evidence of Coverage](#) document, pages 134-140.

(6) How do I reach someone at UChicago about my questions or concerns about the Retiree Medical Plan?

Please reach out to Xaviera Espinoza, your concierge single point of contact for retiree benefits, at 1-773-702-4026 / xaviera@uchicago.edu. The University benefits team is also available Monday through Friday, 8:30am-4:30pm at 1-855-822-8901 / retiree@uchicago.edu.

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Questions about the Anthem Medicare Preferred PPO

Providers, Networks, and Coverage

(1) What providers can I see under the Anthem Medicare Preferred PPO?

You may contact any provider who accepts Medicare to schedule an appointment, though for out-of-network providers a “pre-visit coverage decision” is recommended (see question 6). Out-of-network providers are under no obligation to provide treatment, except in emergency situations. See questions 2 and 3 below for more details on in-network vs. out-of-network differences. A directory of providers that accept Medicare can be accessed directly through Medicare at:

<https://www.medicare.gov/physiciancompare/>

Please note: If you choose to see a provider who does not accept or has opted out of Medicare, the plan will not pay for those services and you will be responsible for all billed charges (except for instances of emergency care).

(2) Who are the in- and out-of-network providers under the Anthem Medicare Preferred PPO?

In-network providers are those who have a contract with Anthem and are part of the “Blue Medicare Advantage PPO” network, a directory of these providers can be obtained by mail by calling Anthem directly, or online as described in question 4. Out-of-network providers are providers who accept Medicare, but do not have this contract and are not part of this network. There are additional differences to be aware of when considering the use of in-network or out-of-network providers. These are detailed in the response to question 3.

(3) What are the differences between using in-network and out-of-network providers?

You have access to any doctor who accepts Medicare and your share of the costs is generally the same, but there are a few key differences between in- and out-of-network providers:

- A. Doctors who accept Medicare but are not part of the Blue Medicare Advantage PPO network are not obligated to treat you except in emergencies, though many will in fact provide routine treatment. Some out-of-network providers may decline to treat you because they do not understand that your Anthem Medicare Preferred PPO plan is a Medicare Advantage Plan (be sure to show the provider your Anthem ID card, not your Medicare card; see question 7). If they decline to treat you because they do not work with Anthem, please contact Xaviera Espinoza in the UChicago Benefits Office at 1-773-702-4026.
- B. If you want to see a doctor who accepts Medicare but is not part of the Blue Medicare Advantage PPO network, you should contact Anthem for a pre-visit coverage decision to confirm that the services you will receive are covered and meet Medicare’s requirements for medical necessity (see question 9).
- C. If your doctor accepts Medicare but is not part of the Blue Medicare Advantage PPO network, they may ask you to pay upfront for services. If you decide to pay upfront, you can submit a request for reimbursement to Anthem, which will reimburse you for the Medicare-allowable

rates for covered services, minus your cost share (see question **21**). More information on this is in the subsection on **Costs and Billing** (page 9).

While you aren't required to get a referral or prior-authorization to use an out-of-network provider who accepts Medicare, it is recommended that you ask the provider to seek a pre-visit coverage decision from Anthem (or request this from Anthem yourself) to ensure that the services you will receive are covered and medically necessary (see question **9**).

For additional information on how to get care from out-of-network providers, see Section 2.2 of the [Evidence of Coverage](#) document (page 30).

(4) How do I check if my provider is in-network?

You may call Anthem's Member Services for this information. Anthem representatives are available Monday through Friday from 8am-9pm EST at 1-833-214-8952. You can also ask for a copy of their printed *Provider Directory* be mailed to you.

You may also confirm online by visiting <https://www.anthem.com>, then:

1. Under the "Medicare" tab at the top left, there are three columns: "Shop," "Care," and "Support."
2. Under "Care," select "Find a Doctor" at the bottom of the list.
3. Scroll down the page to find the section called "Search as Guest" and select "Search by Selecting a Plan or Network." This will open in a new page in your internet browser.
4. On the new page, select "Medical" from the dropdown menu under "What type of care are you searching for?"
5. Under "What state do you want to search in," select the state in which care is needed.
6. Under "Select a plan/network," scroll down until you see the "Medicare" section. Select "Blue Medicare Advantage (PPO)" from that section.
7. Select the "Continue" button.
8. On the next page, select the type of provider you are looking for under "I'm looking for a:" and enter their name in the box to the right. If your provider is a specialist in a particular area of medicine, choose their specialization under "Who specializes in:"
9. Type the zip code, city and state, or state and county names under "Located near:" and select the "Search" button.

In-network providers will be shown in a list with  **Doctor In-Network** at the bottom right of their entry. If you follow the steps above and are unable to locate your provider's name or the search returns no results, please call Anthem's Member Services line (1-833-214-8952) for assistance.

For additional information on how to get care from in-network providers, see Section 2.1 of the [Evidence of Coverage](#) document (page 29)

(5) How do I check if my provider accepts Medicare?

You may call your provider's office to verify. A list of all Medicare-contracted providers can also be found online at <https://www.medicare.gov/physiciancompare/>.

(6) How do I or my out-of-network provider request a pre-visit coverage decision?

Call Anthem’s Member Services at 1-833-214-8952 and request a pre-visit coverage decision for the medical care you are wanting. Standard turnaround time for processing your request is up to 14 calendar days, though based on data as of May 17, 2019, the approval process has taken an average of 1.21 days. In some cases, Anthem may take up to an additional 14 calendar days if you ask for more time or if they need more information to consider your request. Anthem must inform you in writing of their decision to take extra time.

If your health requires it, you can request a “fast coverage decision” or “expedited determination.” If Anthem agrees to provide a fast coverage decision, turnaround time is up to a maximum of 72 hours. Anthem will automatically agree to a fast coverage decision if your provider requests it for you.

Requesting the pre-visit coverage decision does not necessarily mean your services will be authorized. If your request is denied, Anthem will send you a written statement explaining their decision, and you can pursue an appeals process.

For additional information on how to request a pre-visit coverage decision, see Section 5 of the [Evidence of Coverage](#) document (page 82).

(7) I have an Anthem Medicare Preferred PPO plan ID card and my original Medicare card – do I need both?

When you go to a regular medical appointment, you must show your Anthem Medicare Preferred PPO plan ID card. Do not use your Medicare card to obtain this care. (If you provide your Medicare card instead of the Anthem Medicare Preferred PPO card, you may end up having to pay the full cost of the services you receive while using it).

You should retain your Medicare card in case you plan to participate in hospital-based research studies or want or need to obtain hospice services, as they may ask for a Medicare card. Your provider may also ask to see your Medicare card to verify that you are enrolled in Medicare.

(8) What do I do if my doctor says they don’t accept the Anthem Medicare Preferred PPO plan?

In some cases, doctors may say they don’t accept the Anthem Medicare Preferred PPO plan due to a misunderstanding of what your insurance plan really is. It is important that your doctor understand that you still have Medicare, and that the Anthem Medicare Preferred PPO is a Medicare Advantage Plan. You can provide them with the flyer available [here](#) to help educate them on the Anthem Medicare Preferred PPO plan.

As long as your provider accepts Medicare and have agreed to provide you with medically necessary services, they can bill the Anthem Medicare Preferred PPO for your treatment even if they don’t participate in the Blue Medicare Advantage PPO network.

Keep in mind that if you are using an out-of-network provider, you or your doctor should contact Anthem’s Member Services in advance to get a pre-visit coverage decision for the services. There are instructions for providers on the back of your Anthem Medicare Preferred PPO ID card, and your doctor’s office can contact Anthem directly at 1-833-214-8952.

If your doctor is out-of-network, they are not obligated to accept your insurance and can decline to treat you, except in emergencies. In this circumstance, please contact Xaviera Espinoza with the UChicago benefits team, who may be able to work with your provider to resolve the issue: 1-773-702-4026 / xaviera@uchicago.edu

(9) What is “medically necessary” care, and who decides that?

In your Anthem Medicare Preferred PPO documents, you will frequently see that Anthem will pay for services “as long as they are covered and medically necessary.” “Medically necessary” is a common insurance term that means that the services, supplies or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice (see page 29 of your [Evidence of Coverage](#) document). This is determined by Anthem’s Medical Director using national Medicare guidelines, and applies to both non-emergency and emergency services.

(10) Will the Anthem Medicare Preferred PPO continue cover me if I move to another part of the country?

Yes. You can go to any doctor or facility that accepts Medicare anywhere in the United States, Washington D.C, Puerto Rico, Guam, U.S. Virgin Islands, American Samoa, and Northern Mariana Islands. The doctor or facility does not have to be in the Blue Medicare Advantage PPO network, though all of the same in-network/out-of-network differences will still apply.

If you move to another part of the country, remember to update your contact information with the UChicago benefits team.

(11) Will I have insurance when I travel abroad?

The Retiree Medical Plan provides coverage outside of the United States for emergencies and urgent services only, through the Blue Cross Blue Shield Global Core program. This coverage is good for temporary travel up to six months at a time.

A medical emergency is when you believe that you have medical symptoms that require immediate medical attention. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

In an emergency, go directly to the nearest hospital. Call the Blue Cross Blue Shield Global Core Program Service Center at 1-800-810-BLUE (2583) or collect at 1-804-673-1177 when you need to locate a doctor or hospital or need in-patient care. Representatives are available 24 hours a day, 7 days a week, and 365 days a year.

If you anticipate extended travel abroad longer than six months, please contact Xaviera Espinoza on the UChicago benefits team to ensure you and your covered dependents have routine coverage abroad: 1-773-702-4026 / xaviera@uchicago.edu.

Note that the [Retiree Medical Plan Guide](#) you received via mail in 2018 listed “BlueCard Worldwide” as the global insurance. This program changed to “Blue Cross Blue Shield Global Core.”

Costs and Billing

(12) Will I have to pay upfront for any services?

Providers that accept Medicare but are out-of-network may require payment upfront from you. Anthem will reimburse you for the Medicare-allowable rates for all covered services, minus your cost share (see question 21). However, out-of-network providers are encouraged to contact Anthem directly at 1-833-214-8952 for information about how they can bill and receive Medicare-allowable rates for covered services without charging you upfront.

In-network providers do not require payment upfront. See questions 2 through 4 on pages 5-6 for more information on in-network and out-of-network providers.

(13) Where can I/my provider find instructions for how to bill the Anthem Preferred Medicare PPO?

Basic billing instructions for providers are included on the back of your Anthem Preferred Medicare PPO ID card. You may refer your provider to these instructions if questions arise when you go for care. Providers are encouraged to contact Anthem directly at 1-833-214-8952 for information about how to bill and receive payment at the Medicare-allowable rates for covered services.

(14) Has my deductible changed from the 2018 plan for the 65 and over participants?

No. The deductible was \$300 per individual in 2018 and is \$300 per individual in 2019 under the Anthem Medicare Preferred PPO.

(15) Are the Anthem Medicare Preferred PPO copays/coinsurance different from the 2018 plan for the 65 and over participants?

Yes. Copays and coinsurance vary depending on what services you receive. Please refer to the chart on page 5 of your [Retiree Medical Plan Guide](#) for a list of copayments and coinsurance percentages. For example, in 2018 the coinsurance percentage for physician office visits for non-preventive care was 50% for both in- and out-of-network doctors after you paid your deductible. In 2019, the Anthem Medicare Preferred PPO coinsurance percentage for this type of care is 10% after you pay your deductible.

(16) Is the Anthem Medicare Preferred PPO out-of-pocket maximum different from the 2018 plan for the 65 and over participants?

Yes. The out-of-pocket maximum was \$1,750 per family in 2018 and is now \$1,750 per individual under the Anthem Medicare Preferred PPO, though the deductible now counts toward the out-of-pocket maximum (see question 17 below).

(17) Under the Anthem Medicare Preferred PPO, what costs count toward the out-of-pocket maximum, and has that changed from the 2018 plan for 65 and over participants?

Under the Anthem Medicare Preferred PPO, what you pay toward the deductible counts toward the out-of-pocket maximum (which is different than in 2018). In addition, copays and coinsurance payments count (as they did in 2018). Once you reach your out-of-pocket maximum, the Anthem Medicare Preferred PPO pays 100% of the Medicare-allowable amount for covered services.

Please note that Part D prescription copayments, routine hearing services, and copays/coinsurance for foreign travel emergencies/urgent care do not count toward your out-of-pocket maximum.

(18) Do out-of-pocket payments to an out-of-network provider count toward the annual deductible and out-of-pocket maximum?

Yes, if the out-of-network provider accepts Medicare (except where it is noted in the benefits chart of your [Evidence of Coverage](#) document that the deductible does not apply). Payments to a provider who does not accept Medicare are not covered and will not count toward your deductible or out-of-pocket maximum.

Prior Authorization

(19) Some of my Anthem Preferred Medicare PPO documents refer to “prior authorization” for certain services. What is Anthem’s prior authorization process?

Covered services that need prior authorization are identified in the benefits chart located in the Anthem [Evidence of Coverage](#) document.

A review of the service and setting will be made by Anthem’s Medical Director to determine medical necessity using national Medicare guidelines. This review will determine if the services are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice. The provider will need to contact the Provider Services phone number on the back of your ID card to initiate the process.

In-network providers are responsible for seeking prior authorization for services within certain categories, such as inpatient mental health care. These categories are noted with an asterisk in the benefits chart in your [Evidence of Coverage](#) document. In-network providers will know if the service you need must have prior authorization.

Out-of-network providers cannot be required to request prior authorization. However, it is recommended that members request a pre-visit coverage decision (see question 6) from Anthem before any appointments with an out-of-network provider. This will confirm whether the services you want to receive will be covered and meet medical necessity requirements.

Note that the statistics that Anthem reports on approval rates and cycle times for determination referenced elsewhere in this document include both prior authorization requests for select procedures at in-network providers, and pre-visit coverage decisions for out-of-network providers.

(20) What is the turnaround time for prior authorization requests?

Standard turnaround time for processing a prior authorization request is up to 14 calendar days. In some cases, Anthem may take up to an additional 14 calendar days if you ask for more time or if they need more information to consider your request. Anthem must inform you in writing of their decision to take extra time.

If your health requires it, you can request a “fast coverage decision” or “expedited determination.” If Anthem agrees to provide a fast coverage decision, turnaround time is up to 72 hours. Anthem will automatically agree to a fast coverage decision if your provider requests it for you.

Requesting prior authorization does not necessarily mean your services will be authorized. If your request is denied, Anthem will send you a written statement explaining their decision, and you can pursue an appeals process.

For additional information on how to request a coverage decision, see Section 5 of the [Evidence of Coverage](#) document (page 82)

(21) I/my provider received prior authorization for a service but the document I received from Anthem says I may be responsible for a “cost share.” What is that?

In the benefits chart shown in your [Evidence of Coverage](#) document from Anthem, you’ll see that the columns for in-network and out-of-network sometimes list a copay amount or coinsurance percentage for certain services. This is your cost share, and it is typically what you pay either at the time of an appointment or when you receive the final bill from Anthem.

(22) What can I do if I have a problem or complaint regarding Anthem Medicare Preferred PPO’s coverage decision?

For a guide to addressing problems or complaints (including about coverage decisions, appeals, etc.), see Chapter 7 of the [Evidence of Coverage](#) document (page 74).

(23) My provider has done “Peer-to-Peer” conversations with my insurance in the past when claims were denied. Can they do this with Anthem?

Yes. A peer-to-peer conversation with the Anthem Medical Director must be requested by your provider within three (3) calendar days of an “adverse determination notice” (a claim denial). Note that Anthem does not hold these conversations unless requested. Your provider can initiate this request by either sending an email to GRSP2P@anthem.com or calling Anthem’s Member Services at 1-833-607-6514.

(24) What if I have a medical emergency?

If you have an emergency, you should seek care immediately – you do not need to get prior authorization. You may get covered emergency medical care whenever you need it, anywhere in and out of the United States. (A medical emergency is when you believe that you have medical symptoms that require immediate medical attention. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse).

The Anthem Medicare Preferred PPO covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. The doctors who are providing you with emergency care will decide when your condition is stable and the medical emergency is over.

It’s important that someone notifies Anthem’s Member Services (1-833-214-8952) of your medical emergency as soon as possible.

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Glossary of Terms

If you are 65 or over and on Medicare, there are additional definitions included in your Anthem Blue Cross Blue Shield [Evidence of Coverage](#) document, pages 134-140.

Anthem	The administrator of the Anthem Medicare Preferred PPO insurance for plan members age 65 or over and enrolled in Medicare. Also referred to as “Anthem Blue Cross Blue Shield” in some documents.
Anthem Medicare Advantage PPO	See “Anthem Medicare Preferred PPO”
Anthem Medicare Preferred PPO	The insurance plan provided by the Retiree Medical Plan for retirees and/or dependents who are age 65 or over and enrolled in Medicare. It is a Medicare Advantage Plan administered by Anthem.
Blue Cross Blue Shield Global Core	<p>Age 65 and older, enrolled in Medicare: The international travel healthcare program associated with the Retiree Medical Plan for travel less than six months. It provides access to doctors and hospitals for emergency services around the world through Blue Cross Blue Shield for retirees and/or eligible dependents who are age 65 or older and enrolled in Medicare.</p> <p>Age 65 and under, not enrolled in Medicare, or those living outside of the United States: The international travel or permanent residency healthcare program associated with the Retiree Medical Plan. It provides access to doctors and hospitals around the world through Blue Cross Blue Shield for retirees and/or eligible dependents who are age 65 or under and not enrolled in Medicare or who are living outside of the United States for more than six months, regardless of age.</p>
Blue Cross Blue Shield (of Illinois)	The administrator for the insurance available to plan members who are under age 65 and not enrolled in Medicare. Though it mentions Illinois, the Blue Cross Blue Shield of Illinois network extends across the U.S.
Blue Medicare Advantage PPO network	The in-network providers under the Anthem Medicare Preferred PPO plan. If you contact Anthem’s Member Services, ensure they search the Blue Medicare Advantage PPO network and not Anthem’s regular network.
Coinsurance	The percentage of the total cost of certain medical services that you pay.
Copayment (copay)	The fixed amount you pay each time you receive certain medical services.
Deductible	The amount you pay for medical services before your plan begins to pay its share.
In-Network Providers	The facilities, providers and suppliers your health insurer or plan has contracted with to provide healthcare services.



Medicare Advantage Plan	A plan offered by a private company that is approved by Medicare. Medicare Advantage Plans are also sometimes called “Medicare Part C” because they include both Medicare Part A (hospital insurance) and Part B (medical insurance). If you have a Medicare Advantage Plan, you still have Medicare but your insurance is managed and paid for by the Medicare-approved private company (for UChicago, this is Anthem).
Medical Necessity	Services or supplies needed for the prevention, diagnosis, or treatment of a medical condition. This is typically determined by a Medical Director on behalf of your plan administrator (e.g., Anthem).
National Access Plus	A feature of your Anthem Medicare Preferred PPO plan for members age 65 or older and enrolled in Medicare that gives you access to any Medicare doctor nationwide. Your share of the cost is the same for doctors or hospitals not in Anthem’s network.
Out-of-Network Providers	Doctors or other healthcare professionals or facilities that have not arranged to coordinate or provide covered services to members except in emergency situations. These providers are not employed, owned, or operated by the plan administrator and/or are not under contract with the plan administrator to deliver covered services to members.
Peer-to-Peer	The peer-to-peer process facilitates a conversation between your provider and a medical representative of your plan administrator (e.g. the Anthem Medical Director). These conversations can be requested following an adverse determination notice (claim denial) and are usually used to clarify information that your clinical record cannot convey to the insurance administrator.
PPO	Stands for Preferred Provider Organization, which is a medical care arrangement in which medical professionals and facilities provide services to subscribed clients at reduced rates. It is also sometimes used to stand for Preferred Provider Option and Participating Provider Organization, all of which refer to the same concept.
Pre-Visit Coverage Decision	A decision made by the plan administrator (e.g., Anthem) about whether it will cover a medical service before you receive it for members age 65 or older and enrolled in Medicare. You or your provider can ask for a pre-visit coverage decision for you or your covered dependent. Anthem encourages members to request such a determination before seeing an out-of-network provider.
Prior Authorization	An advance approval from the Anthem Medicare Preferred PPO plan to receive covered services from in-network providers. See the benefits chart in your Evidence of Coverage document for a list of services requiring pre-authorization.
Provider	The general term used for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by the State to provide healthcare services.