HIGHMARK®
SENIOR HEALTH COMPANY

January 1 – December 31, 2026

Evidence of Coverage for 2026:

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Freedom Blue PPO

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

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

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

For questions about this document, call Member Services at 1-800-550-8722. (TTY users should call 711 National Relay Service). Hours are Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. This call is free.

This plan, Freedom Blue PPO, is offered by Highmark Senior Health Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Highmark Senior Health Company . When it says "plan" or "our plan," it means Freedom Blue PPO.

This document is available for free in alternate formats such as large print.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2027.

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

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

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2026 Evidence of Coverage

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CHAPTER 1:
Get started as a member

SECTION 1 You're a member of Freedom Blue PPO

Section 1.1 You are enrolled in Freedom Blue PPO, which is a Medicare PPO

You're covered by Medicare, and you chose to get your Medicare health and drug coverage through our plan, Freedom Blue PPO. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Freedom Blue PPO is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

Section 1.2 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with you about how Freedom Blue PPO covers your care. Other parts of this contract include your enrollment form, the List of Covered Drugs (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Freedom Blue PPO between January 1, 2026 and December 31, 2026.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of Freedom Blue PPO after December 31, 2026. We can also choose to stop offering our plan in your service area, after December 31, 2026.

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

SECTION 2 Plan eligibility requirements

Section 2.1 Eligibility requirements

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

- You have both Medicare Part A and Medicare Part B

- You live in our geographic service area (described in Section 2.2). People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.
- You're a United States citizen or lawfully present in the United States.

Section 2.2 Plan service area for Freedom Blue PPO

Freedom Blue PPO is available only to individuals who live in the United States and its territories. To stay a member of our plan, you must continue to reside in the United States and its territories. The service area is described in Chapter 3, section 2.3 *Blue Cross Blue Shield Association Network Sharing* and the *Network Sharing* appendix in the back of this document.

If you move out of our plan's service area, (the United States or its territories) you can't stay a member of this plan. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) to see if we have a plan in your new area. When you move, you'll have a Special Enrollment Period to either switch to Original Medicare or enroll in a Medicare health or drug plan in your new location.

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

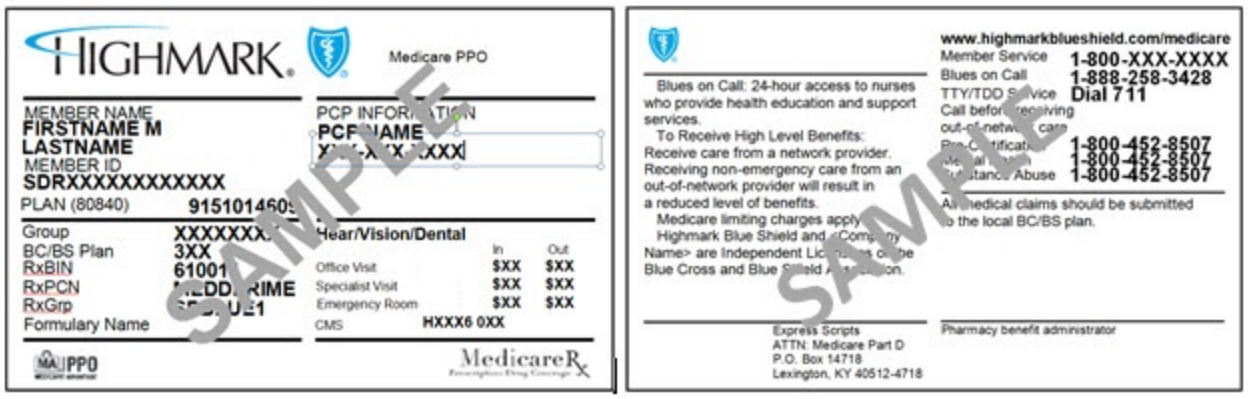
Section 2.3 U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify Freedom Blue PPO if you're not eligible to stay a member of our plan on this basis. Freedom Blue PPO must disenroll you if you don't meet this requirement.

SECTION 3 Important membership materials

Section 3.1 Our plan membership card

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



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

If our plan membership card is damaged, lost, or stolen, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) right away and we'll send you a new card.

Section 3.2 Provider/Pharmacy Directory

The *Provider/Pharmacy Directory* (medicare.highmark.com) lists our current network providers, durable medical equipment suppliers, and pharmacies. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.4 for information on when you can use pharmacies that are not in the plan's network.

Your group may offer a preferred pharmacy network. The *Provider/Pharmacy Directory* will also tell you which of the pharmacies in our network have preferred cost sharing, which may be lower than the standard cost sharing offered by other network pharmacies for some drugs.

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

If you don't have a *Provider/Pharmacy Directory*, you can ask for a copy (electronically or in paper form) from Member Services at 1-800-550-8722 (TTY users should call 711 National Relay

Service). Requested paper Provider/Pharmacy Directories will be mailed to you within 3 business days. You can also find this information on our website at medicare.highmark.com.

Section 3.3 Drug List (formulary)

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

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

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit (medicare.highmark.com) or call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

SECTION 4 Summary of Important Costs for 2026

Summary of Important Costs for 2026 refer to the *Medical Benefit Chart Appendix.*

Section 4.1 Plan premium

This section applies only to members who pay their premium directly to Freedom Blue PPO. If you pay your premium directly to your former employer or union/trust fund, or have your premium deducted from your monthly pension, please call your former employer or union/trust fund benefits administrator for information about your plan premium.

Your coverage is provided through a contract with your current employer or former employer or union/trust fund. As a member of our plan, you may pay a monthly plan premium. Please see the *Medical Benefits Chart* appendix for information about your plan premium if you pay it directly to Freedom Blue PPO.

If you already get help from one of these programs, **the information about premiums in this *Evidence of Coverage*** may not apply to you. We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) and ask for the *LIS Rider*.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. These include Extra Help and State Pharmaceutical Assistance Programs. Chapter 2, Section 7 tells more about these programs. If you qualify, enrolling in the program might lower your monthly plan premium.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of the Medicare & You 2026 handbook in the section called 2026 Medicare Costs. Download a copy from the Medicare website at (www.Medicare.gov/medicare-and-you) or order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 4.2 Monthly Medicare Part B Premium

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium (if applicable), **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you aren't eligible for premium-free Part A.

Section 4.3 Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable prescription drug coverage. Creditable prescription drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable prescription drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

If applicable, the Part D late enrollment penalty is added to your monthly premium. When you first enroll in Freedom Blue PPO, we let you know the amount of the penalty. If you do not pay your Part D late enrollment penalty, you could lose your prescription drug benefits.

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

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from our plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any notice must state that you had creditable prescription drug coverage that is expected to pay as much as Medicare's standard drug plan pays.

- **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.459. This rounds to $5.50. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty**.

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

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

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

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

Section 4.4 Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more

information on the extra amount you may have to pay based on your income, visit www.Medicare.gov/health-drug-plans/part-d/basics/costs.

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

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

Section 4.5 Medicare Prescription Payment Plan Amount

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

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

SECTION 5 More information about your monthly premium

Section 5.1 How to pay our plan premium and/or Part D late enrollment penalty (if applicable)

This section applies only to those members who pay their plan premium or Part D late enrollment penalty directly to Freedom Blue PPO.

There are three ways you can pay your plan premium or Part D late enrollment penalty. When you first enroll in our plan you will be billed monthly.

Option 1: Paying by check

Invoices for your plan premium or Part D late enrollment penalty will be mailed on or about the 4th day of the month. Payment must be received by the last day of the month for the following month. For example, your bill for February coverage will be mailed on or about January 4 and is due by January 31.

Make your check payable to: "Highmark Senior Health Company" or "Freedom Blue PPO". Please include your billing ID number on your check or money order and mail it to us at:

P.O. Box 382054
Pittsburgh, PA 15251-8054

Option 2: Withdrawn from your bank account

You can have your monthly payment automatically deducted from your bank account. This automatic payment program is easy to set up and convenient to use. Simply call Member Services to request an application. Automatic deductions are made monthly on or about the 1st day of the month.

Option 3: Paying online

Our *e*-Bill option is available through our secure website at medicare.highmark.com, if your former employer does **not** contribute to the plan premium. Switching to online e-Bill payment allows you to have your plan premium automatically deducted from your checking account. Online e-Bill payment gives you freedom and flexibility to make a one-time payment while you are temporarily away from home; make recurring payments over several months; view and print your current or past bills, or easily change your checking account information online.

Changing the way you pay your plan premium or Part D late enrollment penalty.

If you decide to change how you pay your plan premium or Part D late enrollment penalty, it can take up to 3 months for your new payment method to take effect. While we process your new payment method, you're still responsible for making sure your plan premium or Part D late enrollment penalty is paid on time. To change your payment method, please contact Member Services.

If you have trouble paying your plan premium or Part D late enrollment penalty

Your plan premium or Part D late enrollment penalty is due in our office by the last day of the month. If we don't get your payment by the last day of the month, we'll send you a notice letting you know our plan membership will end if we don't get your plan premium within three months. If you owe a Part D late enrollment penalty, you must pay the penalty to keep your drug coverage.

If you have trouble paying your premium or Part D late enrollment penalty, if owed, on time, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) to see if we can direct you to programs that will help with your costs.

If we end your membership because you didn't pay your plan premium or Part D late enrollment penalty, if owed, you'll have health coverage under Original Medicare. You may not be able to get Part D drug coverage until the following year if you enroll in a new plan during the Open Enrollment Period. (If you go without creditable drug coverage for more than 63 days, you may have to pay a Part D late enrollment penalty for as long as you have Part D coverage.)

At the time we end your membership, you may still owe us for premiums or penalties. If you want to enroll again in our plan (or another plan that we offer), you'll need to pay the amount you owe before you can enroll.

If you think we wrongfully ended your membership, you can make a complaint (also called a grievance). If you had an emergency circumstance out of your control and that made you unable to pay your plan premium or Part D late enrollment penalty, if owed, within our grace period, you can make a complaint. For complaints, we'll review our decision again. Go to Chapter 9 to learn how to make a complaint or call us at 1-800-550-8722 between Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users should call 711 National Relay Service. You must make your complaint no later than 60 calendar days after the date your membership ends.

Section 5.2 Our monthly plan premium won't change during the year

No. Unless your former employer or union/trust fund makes a change, we're not allowed to change our plan's monthly plan premium amount during the year. If the monthly plan premium changes for next year, we will tell you after your employer or union/trust fund has renewed the contract and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. Or, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This happens if you become eligible for the "Extra Help" program or if you lose your eligibility for the "Extra Help" program during the year. If a member qualifies for "Extra Help" with their prescription drug costs, the "Extra Help" program will pay part of the member's monthly plan premium. A member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the "Extra Help" program in Chapter 2, Section 7.

SECTION 6 Keeping your plan membership record up to date

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

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

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

- Changes to your name, address, or phone number
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- Any liability claims, such as claims from an automobile accident

- If you're admitted to a nursing home
- If you get care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you participate in a clinical research study. (Note: You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

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

SECTION 7 How other insurance works with our plan

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

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service). You may need to give our plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

    - If you're over 65 and you (or your spouse or domestic partner) are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

CHAPTER 2:
Phone numbers and resources

SECTION 1 Freedom Blue PPO contacts

For help with claims, billing, or member card questions, call or write to Freedom Blue PPO Member Services 1-800-550-8722 (TTY users should call 711 National Relay Service). We'll be happy to help you.

Member Services – Contact Information	
CALL	1-800-550-8722 For Prescription drug benefit questions only, call: 1-866-675-8637 Calls to these numbers are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

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

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

Coverage Decisions for Medical Care or Part D prescription drugs – Contact Information	
CALL	Medical coverage decisions: 1-800-550-8722 Prescription drug coverage decisions: 1-866-675-8637

Coverage Decisions for Medical Care or Part D prescription drugs – Contact Information	
	Calls to these numbers are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. To file an expedited medical organization determination, call 1-800-485-9610, option 2.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068 To file an expedited organization determination, send your request to: Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

Appeals for Medical Care or Part D prescription drugs – Contact Information	
CALL	Medical appeals: 1-800-550-8722 Prescription drug appeals: 1-866-675-8637 Calls to these numbers are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. To file an expedited appeal, call 1-800-485-9610, option 2.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

How to make a complaint about your medical care

You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. For more information on making a complaint about your medical care, see

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

Complaints About Medical Care or Pharmacy– Contact Information	
CALL	Medical complaints: 1-800-550-8722 Pharmacy complaints: 1-866-675-8637 Calls to these numbers are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
MEDICARE WEBSITE	You can submit a complaint about Freedom Blue PPO directly to Medicare. To submit an online complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Payment Requests – Contact Information	
CALL	1-800-550-8722 Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068

Payment Requests – Contact Information	
WEBSITE	medicare.highmark.com

SECTION 2 Get help from Medicare

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

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

Medicare – Contact Information	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
CHAT LIVE	Chat live at www.Medicare.gov/talk-to-someone.
WRITE	Write to Medicare at PO Box 1270, Lawrence, KS 66044
WEBSITE	www.Medicare.gov • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly “Wellness” visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit www.Medicare.gov to tell Medicare about any complaints you have about Freedom Blue PPO.

Medicare – Contact Information	
	To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

SECTION 3 State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. Please refer to the ***Agency Contact Information*** in the back of this document for a list of SHIP contact information by state.

SHIP is an independent (not connected with any insurance company or health plan) 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.

SHIP counselors can help you understand your Medicare rights, make complaints about your medical care or treatment, and straighten out problems, with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems, help you understand your Medicare plan choices, and answer questions about switching plans.

SECTION 4 Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. Please refer to the ***Agency Contact Information*** appendix in the back of this document for a list of QIO contact information by state.

QIO has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. QIO is an independent organization. It's not connected with our plan.

Contact QIO in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- You think coverage for your hospital stay is ending too soon.

- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon.

SECTION 5 Social Security

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

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

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

SECTION 6 Medicaid

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

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

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and Medicare Savings Programs, please refer to ***Agency Contact Information*** appendix in the back of this document for a list of Medicaid contact information by state.

SECTION 7 Programs to help people pay for prescription drugs

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

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply any time. To see if you qualify for getting Extra Help:

- Visit https://secure.ssa.gov/i1020/start to apply online.
- Call Social Security at 1-800-772-1213. TTY users call 1-800-325-0778.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

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

- Please call Member Services if you believe you qualify for "Extra Help" and are not being charged the correct cost sharing amount. You will need to provide us with evidence confirming your eligibility for "Extra Help". Documentation confirming your eligibility for "Extra Help" includes, but is not limited to, the following: a copy of your Medicaid card which includes your name and eligibility date, a copy of a state document that confirms active Medicaid status, a copy of a remittance from a nursing facility showing Medicaid payment or a copy of a state document confirming Medicaid payment to a nursing facility.

- When we get the evidence showing the right copayment level, we'll update our system so you can pay the right 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 1-800-550-8722 (TTY users should call 711 National Relay Service) if you have questions.

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

Please see ***Agency Contact Information*** in the back of this document to see if your state has a SPAP. Many states offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you're enrolled in a State Pharmaceutical Assistance Program (SPAP), Medicare's Extra Help pays first.

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

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the ADAP program. Please see ***Agency Contact Information*** in the back of this document for state-specific ADAP contact information.

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

State Pharmaceutical Assistance Programs

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

Please see ***Agency Contact Information*** appendix for state-specific SPAP contact information.

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage, and it can help you manage your costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member

Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or visit www.Medicare.gov.

Medicare Prescription Payment Plan – Contact Information	
CALL	1-866-845-1803 Calls to this number are free. Our hours are 24 hours a day, 7 days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY	1-800-716-3231 This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free. Our hours are 24 hours a day, 7 days a week.
WRITE	Express Scripts Medicare Prescription Payment Plan PO Box 2 Saint Louis, MO 63166 This address is only to be used for general inquiries. Additional addresses will be provided for the paper election forms and for the payment process.
WEBSITE	https://www.express-scripts.com/mppp

SECTION 8 Railroad Retirement Board (RRB)

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

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

SECTION 9 If you have group insurance or other health insurance from an employer

If you (or your spouse or domestic partner) get benefits from your (or your spouse or domestic partner’s) employer or retiree group as part of this plan, call the employer/union benefits administrator or Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) with any questions. You can ask about your (or your spouse or domestic partner’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this document.) You can call 1-800-MEDICARE (1-800-633-4227) with questions about your Medicare coverage under this plan. TTY users call 1-877-486-2048.

If you have other drug coverage through your (or your spouse or domestic partner’s) employer or retiree group, contact **that group’s benefits administrator**. The benefits administrator can help you understand how your current drug coverage will work with our plan.

CHAPTER 3:
Using our plan for your medical services

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

This chapter explains what you need to know about using our plan to get your medical care covered. For details on what medical care our plan covers and how much you pay when you get care, see the *Medical Benefits Chart* appendix.

Section 1.1 Network providers and covered services

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

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

As a Medicare health plan, Freedom Blue PPO must cover all services covered by Original Medicare and follow Original Medicare's coverage rules.

Freedom Blue PPO will generally cover your medical care as long as:

- **The care you get is included in our plan's *Medical Benefits Chart* appendix**.
- **The care you get is considered medically necessary**. Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You get your care from a provider who's eligible to provide services under Original Medicare.** As a member of our plan, you can get care from either a network provider or an out-of-network provider (go to Section 2 for more information).
  - The providers in our network are listed in the *Provider/Pharmacy Directory* (medicare.highmark.com).

- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- Note: While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you go to a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.

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

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

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

When you become a member of Freedom Blue PPO, you may choose a plan provider to be your PCP. Your PCP is a family physician, general practitioner or internal medicine physician who meets state requirements and is trained to give you basic medical care. A PCP can also be a physician assistant or nurse practitioner. Your PCP is one who knows your current health as well as your medical history; a provider with whom you feel comfortable discussing all of your health care needs. You will get your routine or basic care from this provider. Your PCP can also help coordinate the rest of the covered services you get as a member of Freedom Blue PPO. Coordinating your services includes checking or consulting with other plan providers about your care and how it is going. You are encouraged, but not required to see your PCP whenever you need care. This helps ensure that you receive the right care for your needs, when you need it. For your convenience and security, network primary care physicians or their covering doctors are on call 24 hours a day, seven days a week.

How to choose your PCP?

PCPs and their group practices, if applicable, are listed in the *Provider/Pharmacy Directory*. You can also find PCPs on our website at medicare.highmark.com. Click on the **Find a Provider** link to access our online Provider Directory. The name of the PCP's practice and the PCP number for that practice should be included on your Enrollment Application. Because your PCP plays a central role in your health care, please select one with careful consideration to hospital affiliation and office location.

To view board certification information and the hospital affiliation of your PCP or Network specialist, visit our website at medicare.highmark.com. Click on the **Find a Provider** link to access our online Provider Directory. Search for the physician, then click on the provider's name to view this information. In addition to this information, to obtain the full professional qualifications of network providers, including medical schools attended and residencies completed, call Member Services at the numbers printed on the back cover of this document.

How to change your PCP

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

To change your PCP, contact Member Services at the number on the back cover of this document. They will check to be sure the PCP you want is accepting new patients. Member Services will also request the change to your membership record to show the name of the new PCP.

- If your request for change is received between the 1st and the 15th day of the month, your PCP change will become effective the first day of the following month.
- If your request for change is received between the 16th and last day of the month, your PCP change will become effective the first day of the second month after it is received.

Section 2.2 How to get care from specialists and other network providers

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

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

We list the specialists and other network providers that participate with Freedom Blue PPO in the *Provider/Pharmacy Directory.* You can also locate participating network providers on our website, medicare.highmark.com. While you are not required to get a referral from your PCP prior to receiving covered specialty care, you are encouraged to coordinate and record your treatment with your PCP at each stage of your care. This way, you can be sure that your need for specialty care is based on an informed diagnosis. Your PCP can direct you to the right specialist promptly, so you don't waste time tracking down the best doctor for your case. You also can be confident that your specialty care will complement other care you may be receiving. Certain services, such as non-emergency inpatient hospital care, require prior authorization from Highmark Senior Health Company for the service to be covered. Network providers are responsible for obtaining this prior authorization (for more information on which services require prior authorization, see the *Medical Benefits Chart* appendix).

If you believe you need **treatment for mental health or substance abuse**, contact the network behavioral health provider of your choice or call Member Services at the toll-free / TTY number on the back of your member ID card and select the *mental health, drug or alcohol treatment services* option from the menu. You will be connected to Highmark Behavioral Health Department, which is available Monday through Friday, 8:30 a.m. through 7:00 p.m., Eastern Time. The Highmark Behavioral Health Department is a valuable resource for accessing information about mental health and substance abuse providers, facilities and related information.

When a specialist or another network provider leaves our plan

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

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

Section 2.3 Blue Cross Blue Shield Association Network Sharing

Freedom Blue PPO members have access to the Blue Cross Blue Shield Association service area providers. Freedom Blue PPO members may visit any participating Blue Cross and/or Blue Shield Medicare Advantage PPO provider in any geographic area where the Part A, Part B and supplemental services of Blue Cross Blue Shield providers are offered, and pay network cost sharing.

The Service Area includes specific counties in the following 48 states and 2 territories: Alabama, Arizona, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina, South Dakota, Tennessee,

Texas, Utah, Vermont, Virginia, Washington, Wisconsin, West Virginia, and Wyoming. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state. ***See the Network Sharing appendix in the back of this book for a list of BCBSA network sharing counties by state*.**

To find Blue Cross and/or Blue Shield Medicare Advantage PPO providers in the above locations, you may:

- Call Freedom Blue PPO Member Services (numbers on the back of your ID card), Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Hearing-impaired TTY users call 711 National Relay Service.
- Visit medicare.highmark.com and select "Find Providers" or visit "Find a Doctor" at www.BCBS.com.

Freedom Blue PPO members may see any Blue Cross and/or Blue Shield Medicare Advantage PPO contracted doctor or hospital in the above locations and receive coverage at the highest level of benefits. If you receive routine/non-emergent care from non-participating providers in the above 48 states and 2 territories, you will receive a lower level of benefits, which will result in higher out-of-pocket costs.

In locations where participating Blue Cross and/or Blue Shield Medicare Advantage PPO providers are not available, members may visit **any Medicare-eligible provider** and receive coverage at the highest level of benefits.

***Emergency and urgently needed care is always covered at the higher network level of benefits, regardless of where the care is received*.**

You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

Section 2.4 What you pay for covered services

The following charts are for members **who live** within a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to the following providers and receive:

In-Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Full coverage after you pay a small copayment or coinsurance	80%* coverage after you pay an annual deductible

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	In-Network Doctors/ Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage after you pay a small copayment or coinsurance	80%* coverage after you pay an annual deductible
***Without* a participating Medicare Advantage PPO network**	Full coverage after you pay a small copayment or coinsurance	Full coverage after you pay a small copayment or coinsurance

* The amount you pay may be more or less depending on your specific plan's out-of-network cost sharing benefit design. Your costs may be higher if you receive services from a non-network provider who does not accept Medicare assignment. Call Member Services for details.

The following charts are for members who **do not live** in a county that includes participating Blue Cross and/or Blue Shield Medicare Advantage providers.

While at home, you can go to any Medicare participating provider in your county and receive:

In-Network Doctors and Hospitals	Non-Network Doctors and Hospitals
Full coverage after you pay a small copayment or coinsurance	Full coverage after you pay a small copayment or coinsurance

When traveling outside of your county or across the country, you can go to the following providers and receive:

If you seek care in a county…	In-Network Doctors/ Hospitals	Non-Network Doctors/Hospitals
***With* a participating Medicare Advantage PPO network**	Full coverage after you pay a small copayment or coinsurance	80%* coverage after you pay an annual deductible
***Without* a participating Medicare Advantage PPO network**	Full coverage after you pay a small copayment or coinsurance	Full coverage after you pay a small copayment or coinsurance

* The amount you pay may be more or less depending on your specific plan's out-of-network cost sharing benefit design. Your costs may be higher if you receive services from a non-network provider who does not accept Medicare assignment. Call Member Services for details.

When you call a provider's office to make an appointment, be sure to tell them that you have coverage through a Blue Cross and/or Blue Shield Medicare Advantage PPO. And when you visit, show them your Freedom Blue PPO ID card. It's important that you show your Freedom Blue PPO ID card to the provider when you seek medical care. Your card has a special "suitcase" in the lower left corner of the card. This suitcase alerts your doctor, hospital or other provider that you are a member of a Blue Cross and/or Blue Shield Medicare Advantage PPO. It also directs

them to file any claims for services they provide to their local Blue Cross and/or Blue Shield Plan.

The cost of the service, on which member liability (copayment/coinsurance) is based, will be either:

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

Section 2.5 How to get care from out-of-network providers

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

- You can get your care from an out-of-network provider; however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If you get care from a provider who isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get. Check with your provider before getting services to confirm that they're eligible to participate in Medicare.
- You don't need a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers, ask for a pre-visit coverage decision to confirm that the services you get are covered and medically necessary (go to Chapter 9, Section 4). This is important because:
  - Without a pre-visit coverage decision, and if our plan later determines that the services aren't covered or weren't medically necessary, our plan may deny coverage and you'll be responsible for the entire cost. If we say we won't cover the services you got, you have the right to appeal our decision not to cover your care (go to Chapter 9).
- It's best to ask an out-of-network provider to bill our plan first. But, if you've already paid for the covered services, we'll reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill you think we should pay, you can send it to us for payment (go to Chapter 7).
- If you're using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount (go to Section 3).

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

Section 3.1 Get care if you have a medical emergency

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

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere in the United States, its territories or worldwide, and from any provider with an appropriate state license even if they're not part of our network.
- As soon as possible, make sure our plan has been told about your emergency. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. You can reach Member Services at the number included on the back of this book. You can also locate the phone number on the back of your 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.

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

After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. Your follow-up care will be covered by our plan.

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

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say

that it wasn't a medical emergency after all. If it turns out that it wasn't an emergency, as long as you reasonably thought your health was in serious danger, we'll cover your care.

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

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

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

If you believe you have an urgent need for care, go to the nearest emergency room or urgent care facility. Urgent care centers are located on our website at medicare.highmark.com. **Note:** If you go to the emergency room, your cost sharing could be higher. See the *Medical Benefits Chart* appendix for more information.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

- injury
- sudden illness
- medical condition that is quickly getting worse

Section 3.3 Get care during a disaster

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

Visit medicare.highmark.com for information on how to get needed care during a disaster.

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

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

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

Section 4.1 If services aren't covered by our plan, you must pay the full cost

Freedom Blue PPO covers all medically necessary services as listed in the *Medical Benefits Chart* appendix. If you get services that aren't covered by our plan, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. These payments will not count toward your out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

SECTION 5 Medical services in a clinical research study

Section 5.1 What is a clinical research study

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

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

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

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

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

Section 5.2 Who pays for services in a clinical research study

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

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> *Example of cost sharing in a clinical trial:* Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

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

Get more information about joining a clinical research study

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

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

Section 6.1 A religious non-medical health care institution

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

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

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

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

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

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

All Medicare Inpatient Hospital coverage limits apply. See the *Medical Benefits Chart* appendix for more information.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 You won't own some durable medical equipment after making a certain number of payments under our plan

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

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of Freedom Blue PPO, you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under some limited circumstances, we'll transfer ownership of the DME item to you. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) for more information.

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

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

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

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 7.2 Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, Freedom Blue PPO will cover:

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

If you leave Freedom Blue PPO or no longer medically require oxygen equipment, the oxygen equipment must be returned.

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

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

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

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

This chapter focuses on your covered services and what you pay for your medical benefits. The *Medical Benefits Chart* appendix lists your covered services and shows how much you will pay for each covered service as a member of Freedom Blue PPO. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services.

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

Types of out-of-pocket costs you may pay for covered services include.

- **Deductible:** the amount you must pay for medical services before our plan begins to pay its share.
- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don’t pay deductibles, copayments or coinsurance. If you’re in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 Our plan deductible

Your deductible (if applicable, see the *Medical Benefits Chart* appendix for details on your specific coverage) is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you’ve paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible, if applicable, does not apply to the services that are listed below.) After you pay your deductible, we’ll start to pay our share of the costs for covered medical services, and you’ll pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible doesn’t apply to some services. This means that we pay our share of the costs for these services even if you haven’t paid your deductible yet. The deductible doesn’t apply to specific services see the *Medical Benefits Chart appendix*.

Section 1.3 What’s the most you’ll pay for Medicare Part A and Part B covered medical services?

Under our plan, there are 2 different limits on what you pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** can be found in the *Medical Benefits Chart* appendix. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from network providers. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums, Part D drugs, and services from out-of-network providers don’t count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are noted as such in the *Medical Benefits Chart* appendix.) If you pay the in-network maximum out-of-pocket for covered Part A and Part B services from network providers, you won't have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).
- Your **combined maximum out-of-pocket amount** can be found in the *Medical Benefits Chart* appendix. This is the most you pay during the calendar year for covered Medicare Part A and Part B services you got from both in-network and out-of-network. The amounts you pay for deductibles (if applicable), copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for plan premiums and for your Part D drugs don’t count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are noted as such in the *Medical Benefits Chart* appendix.) If your combined maximum out-of-pocket amount for covered services has been met, you will have 100% coverage and won't have any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium, if applicable, and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan also limits your out-of-pocket costs for certain types of services

In addition to the in-network and combined maximum out-of-pocket amounts for covered Part A and Part B services (see Section 1.3 above and the *Medical Benefits Chart* appendix), your plan may also have a separate maximum out-of-pocket amount that applies only to certain types of

services that can be found in the *Medical Benefits Chart* appendix. If applicable, once you have paid the out-of-pocket amount, the plan will cover these services at no cost to you for the rest of the calendar year.

Section 1.5 Providers aren’t allowed to balance bill you

As a member of Freedom Blue PPO, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can’t bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service and even if there’s a dispute and we don’t pay certain provider charges.

Here's how protection from balance billing works:

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), you pay only that amount for any covered services from a network provider. You’ll generally have higher copayments when you get care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan’s reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
  - If you get covered services from an out-of-network provider who doesn’t participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you think a provider has balance billed you, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

SECTION 2 The Medical Benefits Chart shows your medical benefits and costs

The *Medical Benefits Chart* appendix which lists your covered services is provided separately in the Welcome Kit when you first joined the plan. It is then provided every year with the *Annual Notice of Changes* (ANOC) you receive during the Annual Election Period.

SECTION 3 Services that aren't covered by our plan (exclusions)

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

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we made to not cover a medical service, go to Chapter 9, Section 5.3.)

Services not covered by Medicare	Covered only under specific conditions
Acupuncture	Available for people with chronic low back pain under certain circumstances Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Cosmetic surgery or procedures	Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance
Custodial care Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Experimental medical and surgical procedures, equipment, and medications Experimental procedures and items are those items and procedures determined by Original Medicare to not be generally accepted by the medical community	May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan (Go to Chapter 3, Section 5 for more information on clinical research studies)
Fees charged for care by your immediate relatives or members of your household	Not covered under any condition
Full-time nursing care in your home	Not covered under any condition
Home-delivered meals	Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Homemaker services include basic household help, including light housekeeping or light meal preparation	Not covered under any condition
Naturopath services (uses natural or alternative treatments)	Not covered under any condition
Non-routine dental care	Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet	Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	Not covered under any condition

Services not covered by Medicare	Covered only under specific conditions
Private room in a hospital	Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies	Not covered under any condition
Routine chiropractic care	Manual manipulation of the spine to correct a subluxation is covered. Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Routine dental care, such as cleanings, filling or dentures	Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids	Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Routine foot care	Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Routine hearing exams, hearing aids, or exams to fit hearing aids	Your specific group benefit plan may have additional coverage, please see the *Medical Benefits Chart* appendix.
Services considered not reasonable and necessary, according to Original Medicare standards	Not covered under any condition
Telehealth services other than those listed in the *Medical Benefits Chart* appendix	Not covered under any condition

CHAPTER 5:
Using plan coverage for Part D drugs

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

This chapter **explains rules for using your coverage for Part D drugs**. Please see your *Medical Benefits Chart* appendix for Medicare Part B drug benefits and hospice drug benefits.

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

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

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

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

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

Section 2.1 Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Provider/Pharmacy Directory*, visit our website (medicare.highmark.com), and/or call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

You may go to any of our network pharmacies. If your employer coverage has a preferred network (see your *Part D Prescription Drugs* appendix), some network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost sharing. The *Provider/Pharmacy Directory* will tell you which network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. If the pharmacy you use stays in our network but no longer offers preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if available. To find another pharmacy in your area, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or use the *Provider/Pharmacy Directory*. You can also find information on our website at medicare.highmark.com.

Specialized pharmacies

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on its use. To locate a specialized pharmacy, go to your *Provider/Pharmacy Directory* (medicare.highmark.com) or call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

Section 2.2 Our plan's mail-order service

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

To get order forms and information about filling your prescriptions by mail call Member Services.

Usually, a mail-order pharmacy order will be delivered to you in no more than 10 days. If your mail-order shipment is delayed, please call Express Scripts Pharmacy 24 hours a day, seven days a week at 1-800-294-8216 (TTY users call 711 National Relay Service).

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

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

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

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

If you used mail order in the past and don't want the pharmacy to automatically fill and ship each new prescription, contact us by calling Express Scripts Home Delivery 24 hours a day, seven days a week at 1-800-294-8216 (TTY users call 711 National Relay Service) or calling Member Services at 1-800-550-8722, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users call 711 National Relay Service.

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

To opt out of automatic deliveries of new prescriptions received directly from your health care provider's office, contact us by calling Express Scripts Home Delivery 24 hours a day, seven days a week at 1-800-294-8216 (TTY users call 711 National Relay Service) or calling Member Services at 1-800-550-8722, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. TTY users call 711 National Relay Service.

Refills on mail-order prescriptions. For refills, contact your pharmacy 21 days before your current prescription will run out to make sure your next order is shipped to you in time.

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

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

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Provider/Pharmacy Directory* (medicare.highmark.com) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information.
2. You can also get maintenance drugs through our mail-order program. Go to Section 2.3 for more information.

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

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. We also have network pharmacies outside of our service area where you can get prescriptions filled as a member of our plan. **Check first with Member Services 1-800-550-8722 (TTY users should call 711 National Relay Service)** to see if there's a network pharmacy nearby.

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

Getting coverage when you travel or are away from the plan's service area

If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through our mail-order pharmacy service.

If you are traveling within the United States and its territories and become ill, lose or run out of your prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription in addition to the appropriate network copayment. We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and its territories, even for a medical emergency.

Medical emergency or urgent care

We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care. If you go to an out-of-network pharmacy, you may be responsible for paying the difference between what we would pay for a prescription filled at a network pharmacy and what the out-of-network pharmacy charged for your prescription in addition to the appropriate network copayment.

Other times you can get your prescription covered if you go to an out of network pharmacy

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.

- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and is administered in your doctor's office.
- If you were evacuated or displaced from your residence due to a state or federally declared disaster or health emergency.

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

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

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

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

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

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

- Approved by the FDA for the diagnosis or condition for which it's prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

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

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

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product

at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

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

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 Five cost-sharing tiers for drugs on the Drug List

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

- Cost Sharing Tier 1 includes preferred generic drugs and is the lowest cost sharing tier.
- Cost Sharing Tier 2 includes generic drugs.
- Cost Sharing Tier 3 includes preferred brand name drugs and generic drugs.
- Cost Sharing Tier 4 includes non-preferred brand name drugs and generic drugs.
- Cost Sharing Tier 5 includes specialty drugs and is the highest cost sharing tier.

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

The amount you pay for drugs in each cost sharing tier is shown in the *Part D Prescription Drugs* appendix.

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

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

1. Check the most recent Drug List we provided electronically.
2. Visit our plan's website (medicare.highmark.com). The Drug List on the website is always the most current.
3. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) to find out if a particular drug is on our plan's Drug List or ask for a copy of the list.
4. Use our plan's "Real-Time Benefit Tool" (medicare.highmark.com to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

SECTION 4 Drugs with restrictions on coverage

Section 4.1 Why some drugs have restrictions

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

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

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

Section 4.2 Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception.** We may or may not agree to waive the restriction for you (go to Chapter 9).

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan's prior authorization criteria can be obtained by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or on our website medicare.highmark.com.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**. Our plan's step therapy criteria can be obtained by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or on our website medicare.highmark.com.

Quantity limits

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

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

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

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

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

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

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

You may be able to get a temporary supply

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

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

- **If you're a new member,** we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year,** we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
- This temporary supply will be for a maximum of 31 days. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of 31 days of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.

For questions about a temporary supply, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

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

1) You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

2) You can ask for an exception

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

If you're a current member and a drug you take will be removed from the formulary or restricted in some way for next year, we'll tell you about any change before the new year. You can ask for an exception before next year and we'll give you an answer 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.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

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

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

You can change to another drug

If your drug is in a cost sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost sharing tier that might work just as well for you. Call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

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

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6 Our Drug List can change during the year

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

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

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

Information on changes to drug coverage

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

Changes to drug coverage that affect you during this plan year

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

- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost sharing tier, add new restrictions, or both. The version of the drug that we add will be on the same or a lower cost sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We'll tell you at least 30 days before we make the change or tell you about the change and cover a 31-day fill of the version of the drug you're taking.
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - Sometimes a drug may be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - We may make other changes once the year has started that affect drugs you are taking. For example, based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 31-day fill of the drug you're taking.

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

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

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

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

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

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

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

SECTION 7 Types of drugs we don't cover

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

If you get drugs that are excluded, you must pay for them yourself (except for certain excluded drugs covered under our enhanced drug coverage). If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

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

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

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

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

Your former employer/union/trust fund ***may*** offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. If applicable, a list of these drugs is included in the *Part D Prescription Drugs* appendix. The amount

you pay for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in the *Part D Prescription Drugs* appendix.)

If you **get Extra Help from Medicare** to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) for more information. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 How to fill a prescription

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

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

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

SECTION 9 Part D drug coverage in special situations

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

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

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

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

Check your *Provider/Pharmacy Directory* (medicare.highmark.com) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 If you also have drug coverage from an employer or retiree group plan

If you have other drug coverage through your (or your spouse or domestic partner's) employer or retiree group, contact **that group's benefits administrator**. They can help you understand how your current drug coverage will work with our plan.

In general, if you have employee or retiree group coverage, the drug coverage you get from us will be *secondary* to your group coverage. That means your group coverage pays first.

Special note about creditable coverage:

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 If you're in Medicare-certified hospice

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

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

SECTION 10 Programs on drug safety and managing medications

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

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

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

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

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

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

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies)
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain doctor(s)
- Limiting the amount of opioid or benzodiazepine medications we will 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 prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of

your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

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

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

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

CHAPTER 6:
What you pay for your Part D drugs

SECTION 1 What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) and ask for the *LIS Rider*.

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (medicare.highmark.com), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

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

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

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

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

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

These payments are included in your out-of-pocket costs

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

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

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $2100 in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

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

- Your monthly plan premium (if applicable)
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan
- Payments you make toward drugs not normally covered in a Medicare Prescription Drug Plan
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

Tracking your out-of-pocket total costs

- The Part D Explanation of Benefits (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches $2100, the Part D EOB will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up to date.

SECTION 2 Drug payment stages for Freedom Blue PPO members

There are **3 drug payment stages** for your drug coverage under Freedom Blue PPO. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

The *Part D Prescription Drugs* appendix which lists your covered drugs is provided separately in the Welcome Kit when you first joined the plan. It is then provided every year with the *Annual Notice of Changes* (ANOC) you receive during the Annual Election Period.

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

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

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).

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

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

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

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

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

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

- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get a Part D EOB, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service). Be sure to keep these reports.

SECTION 4 The Deductible Stage

If your plan does not have a Part D prescription drug deductible: You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

If your plan has a Part D prescription drug deductible: The Deductible Stage is the first payment stage for your drug coverage. This stage begins when you fill your first prescription in the year. When you are in this payment stage, **you must pay the full cost of your drugs** until you reach the plan's deductible amount (refer to the *Part D Prescription Drugs* appendix for this amount).The deductible doesn't apply to covered insulin products and most adult Part D vaccines, including shingles, tetanus, and travel vaccines. The **full cost** is usually lower than the normal full price of the drug since our plan has negotiated lower costs for most drugs at network pharmacies.

Once you pay the deductible amount for your drugs, if applicable, you leave the Deductible Stage and move on to the Initial Coverage Stage.

SECTION 5 The Initial Coverage Stage

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

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

Our plan has five cost sharing tiers

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

- Cost Sharing **Tier 1** includes preferred generic drugs and is the lowest cost sharing tier.
- Cost Sharing **Tier 2** includes generic drugs.
- Cost Sharing **Tier 3** includes preferred brand name drugs and generic drugs. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin, and specific service category or plan level deductibles do not apply.
- Cost Sharing **Tier 4** includes non-preferred brand name drugs and generic drugs. Insulin cost sharing is subject to a coinsurance cap of $35 for one-month's supply of insulin, and specific service category or plan level deductibles do not apply.
- Cost Sharing **Tier 5** includes specialty drugs and is the highest cost sharing tier.

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

Your pharmacy choices

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

- A network retail pharmacy that offers standard cost sharing
- A network retail pharmacy that offers preferred cost sharing (if applicable). Costs may be less at pharmacies that offer preferred cost sharing
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.4 to find out when we'll cover a prescription filled at an out-of-network pharmacy
- Our plan's mail-order pharmacy

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and our plan's *Provider/Pharmacy Directory* (medicare.highmark.com).

Your specific group benefit plan determines the level of prescription drug coverage you have. Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.

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

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

The amount of the copayment or coinsurance depends on which cost sharing tier your drug is in.

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

Your specific group benefit plan determines the level of prescription drug coverage you have. Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.

Please see Section 7 of this chapter for more information on cost sharing for Part D Vaccines.

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

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

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

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

Section 5.4 Your costs for a *long-term* (up to a 90-day but no more than a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is at least a 90-day supply and no more than a 100-day supply of the drug.

The table included in the *Part D Prescription Drugs* appendix shows what you pay when you get a long-term supply of a drug.

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

Your specific group benefit plan determines the level of prescription drug coverage you have. Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.

Section 5.5 You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2100.** You then move to the Catastrophic Coverage Stage.

The *Part D EOB* you get will help you keep track of how much you, the plan, and any third parties have spent on your behalf for your drugs during the year. Not all members will reach the $2100 out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.2 for more information on how Medicare calculates your out-of-pocket costs.

If your former employer or union/trust fund offers additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan, payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, refer to your *Part D Prescription Drugs* appendix.

SECTION 6 The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the $2100 limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

- During this stage, you pay nothing for your covered Part D drugs.
- If applicable, you may have cost sharing for drugs that are covered under our enhanced excluded drug benefit.

Your specific group benefit plan determines the level of prescription drug coverage you have. Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.

SECTION 7 What you pay for Part D vaccines

Important message about what you pay for vaccines - Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you, even if you haven't paid your deductible (if applicable). Refer to our plan's Drug List or call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) for coverage and cost-sharing details about specific vaccines.

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAPTER 7:
Asking us to pay our share of a bill for covered medical services or drugs

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

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

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

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

1. **When you got medical care from a provider who's not in our plan's network**

   When you got care from a provider who isn't part of our network, you're only responsible for paying your share of the cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) Ask the provider to bill our plan for our share of the cost.

   - Emergency providers are legally required to provide emergency care. You're only responsible for paying your share of the cost for emergency or urgently needed services. If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - If the provider is owed anything, we'll pay the provider directly.

- If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

- While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we can't pay a provider who isn't eligible to participate in Medicare. If the provider isn't eligible to participate in Medicare, you'll be responsible for the full cost of the services you get.

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

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

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

3. If you're retroactively enrolled in our plan

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

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

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

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

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

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

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

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

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

   You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

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

7. **If you've paid for a flu shot.**

   - Flu shots can be given in a provider's office or in another setting such as a community flu shot clinic. Flu shots given in a provider's office and billed directly to Freedom Blue PPO are covered in full. If you receive a flu shot in another setting, you may be required to pay the full cost of the shot up front. If you are required to pay for the full cost of the flu shot, obtain a receipt and send a copy to us asking us to pay you back for our share of the cost. We will reimburse you the Medicare-approved amount. You will be responsible for paying the difference between the provider's charge and the Medicare-approved amount. For more information on your coverage for immunizations, see the *Medical Benefits Chart* appendix.

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

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

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months** of the date you got the service, item, or drug.

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

- You don't have to use the form, but it will help us process the information faster. Please include your name, member number from your identification card, address, phone number and a copy of an itemized receipt.
- Download a copy of the form from our website (medicare.highmark.com) or call Member Services and ask for the form.

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

P.O. Box 1068 Pittsburgh, PA 15230-1068

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

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

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

Section 3.1 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

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

CHAPTER 8:
Your rights and responsibilities

SECTION 1 Our plan must honor your rights and cultural sensitivities

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

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

Our plan has free interpreter services available to answer questions from non-English speaking members. We can also give you information in braille, in large print, or other alternate formats at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

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

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

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services at 1-800-550-8722. You can also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights 1-800-368-1019 or TTY 1-800-537-7697.

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

You have the right to choose a provider in our plan's network.

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

If you think you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

We are committed to protecting your privacy and personal health information (PHI). This includes PHI discussed verbally. Some of the ways we protect your privacy includes not discussing PHI outside of our offices, as well as verifying your identity before we discuss PHI with you over the phone. You can also read our Notice of Privacy Practices (NPP) on our website. Log onto https://www.highmarkhealth.org/hmk/privacy.shtml.

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

As a member of Freedom Blue PPO, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services.

- **Information about our plan**. This includes, for example, information about the plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug is not covered or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

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

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

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

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

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

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

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with:

For complaints about doctors in Pennsylvania:

Department of State
Bureau of Professional and Occupational Affairs Compliance Office
P.O. Box 2649
Harrisburg, PA 17105
717-787-8503
www.dos.pa.gov/Pages/File-a-Complaint.aspx

For complaints about hospitals in Pennsylvania:

Pennsylvania Department of Health
Division of Acute and Ambulatory Care
H&W Building, Room 532
625 Forster Street
Harrisburg, PA 17120
1-717-783-8980
apps.health.pa.gov/dohforms/FacilityComplaint.aspx

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

If you have any problems, concerns, or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

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

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

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

- **Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service)**.
- **Call your local SHIP**. For details, refer to the Agency Contact Information in the back of this document for a list of SHIP contact information by state.
- **Call Medicare** at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

Section 1.8 How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service)**
- **Call your local SHIP.** For details, refer to the Agency Contact Information in the back of this document for a list of SHIP contact information by state.
- **Contact Medicare**
  - Visit www.Medicare.gov to read the publication Medicare Rights & Protections (available at: (Medicare Rights & Protections)
  - Call 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048)

SECTION 2 Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about your medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or Part D drugs.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.

- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - You must pay our plan premiums (if applicable).
  - You must continue to pay your Medicare Part B premiums to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your drug coverage.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan.**
- **If you move, tell Social Security (or the Railroad Retirement Board).**

CHAPTER 9:
If you have a problem or complaint (coverage decisions, appeals, complaints)

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

This chapter explains 2 types of processes for handling problems and concerns:

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

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

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 Legal terms

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

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

SECTION 2 Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help

you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers and website URLs refer to the Agency Contact Information in the back of this document for a list of SHIP contact information by state.

Medicare

You can also contact Medicare for help:

- Call 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048
- Visit www.Medicare.gov

SECTION 3 Which process to use for your problem

Is your problem or concern about your benefits or coverage?

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

Yes.

Go to **Section 4, A guide to coverage decisions and appeals.**

No.

Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service or other concerns.**

Coverage decisions and appeals

SECTION 4 A guide to coverage decisions and appeals

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

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network

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

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

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

Making an appeal

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

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- **Section 5.4** of this chapter for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

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

Section 4.1 Get help asking for a coverage decision or making an appeal

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

- **Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service)**
- **Get free help** from your State Health Insurance Assistance Program.
- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) and ask for the Appointment of Representative form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.highmark.com)
    - For medical care or Part B drugs, your doctor can ask for a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2.
    - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
    - If you want a friend, relative, or other person to be your representative, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) and ask for the Appointment of Representative form. (The form is also available at www.CMS.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.highmark.com). This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
    - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations in this chapter:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (Applies only to these services: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

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

SECTION 5 Medical care: How to ask for a coverage decision or make an appeal

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

Your benefits for medical care are described in the *Medical Benefits Chart* appendix. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't not pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**

5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 How to ask for a coverage decision

Legal Terms
A coverage decision that involves your medical care is called an **organization determination.** A fast coverage decision is called an **expedited determination.**

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

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services already got).
- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

If your doctor tells us that your health requires a fast coverage decision, we will automatically agree to give you a fast coverage decision.

If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision. If we do not approve a fast coverage decision, we will send you a letter that:

- Explains that we will use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we will automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

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

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

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

For standard coverage decisions we use the standard deadlines

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe

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

- **However,** if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we shouldn't take extra days, you can file a fast complaint. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

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

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

Section 5.3 How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you are asking for a standard appeal, submit your standard appeal in writing.**You may also ask for an appeal by calling us. Chapter 2 has contact information.
- **If you are asking for a fast appeal, make your appeal in writing or call us.** Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal.**

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

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

Deadlines for a fast appeal

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

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for,** we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug.
- **If our plan says no to part or all of your appeal,** we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 The Level 2 appeal process

Legal Terms
The formal name for the Independent Review Organization is the **Independent Review Entity.** It is sometimes called the **IRE.**

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

Step 1: The independent review organization reviews your appeal.

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

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

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

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

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

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

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

- **If the review organization says yes to part or all of a request for a medical item or service,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests. For expedited requests, we have 72 hours from the date we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug within 72 hours after we get the decision from the independent review organization for standard requests. For expedited requests we have 24 hours from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called upholding the decision or turning down your appeal.). In this case, the independent review organization will send you a letter:
  - Explain the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tell you how to file a Level 3 appeal.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 If you're asking us to pay you for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

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

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

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

To make this appeal, follow the process for appeals in Section 5.3. For appeals concerning reimbursement, note:

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

SECTION 6 Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **This section is about your Part D drugs only.** To keep things simple, we generally say *drug* in the rest of this section, instead of repeating *covered outpatient prescription drug* or *Part D drug* every time. We also use the term Drug List instead of *List of Covered Drugs* or formulary.

- If you do not know if a drug is covered or if you meet the rules, you can ask us. Some drugs require that you get approval from us before we will cover it.
- If your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Terms
An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. This section tells what you can do if you are in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**
- Asking to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**
- Asking to pay a lower cost sharing amount for a covered drug on a higher cost sharing tier. **Ask for an exception. Section 6.2**
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.4**
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**

If you disagree with a coverage decision we made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal.

Section 6.2 Asking for an exception

Legal Terms
Asking for coverage of a drug that is not on the Drug List is a **formulary exception.** Asking for removal of a restriction on coverage for a drug is a **formulary exception.** Asking to pay a lower price for a covered non-preferred drug is a **tiering exception.**

If a drug is not covered in the way you would like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you will need to pay the cost sharing amount that applies to drugs in Tier 4. You cannot ask for an exception to the cost sharing amount we require you to pay for the drug.

2. **Removing a restriction for a covered drug**. Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost sharing amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on our Drug List is in one of five cost sharing tiers. In general, the lower the cost sharing tier number, the less you will pay as your share of the cost of the drug.

- If our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost sharing tier than your drug, you can ask us to cover your drug at the cost sharing amount that applies to the alternative drug(s).
- If the drug you're taking is a biological product you can ask us to cover your drug at a lower cost sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition.
- If the drug you're taking is a brand name drug you can ask us to cover your drug at the cost sharing amount. This would be the lowest tier that contains brand name alternatives for treating your condition.
- If the drug you're taking is a generic drug you can ask us to cover your drug at the cost sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition.
- You cannot ask us to change the cost sharing tier for any drug in Specialty Tier 5.
- If we approve your tiering exception request and there is more than one lower cost sharing tier with alternative drugs you can't take, you will usually pay the lowest amount.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Our Drug List typically includes more than one drug for treating a particular condition. These different possibilities are called **alternative** drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception. If you ask us for a tiering exception, we will generally *not* approve your request for an exception unless all the alternative drugs in the lower cost sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request, you can ask for another review by making an appeal.

Section 6.4 How to ask for a coverage decision, including an exception

Legal Terms
A fast coverage decision is called an **expedited coverage determination.**

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet two requirements:**

- You must be asking for a drug you didn't get yet. (You can't ask for fast coverage decision to be paid back for a drug you have already bought.)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision, we will automatically give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we will decide whether your health requires that we give you a fast coverage decision.** If we do not approve a fast coverage decision, we will send you a letter that:
  - Explains that we will use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we will automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. We will answer your complaint within 24 hours of receipt.

Step 2: As for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form* or on our plan's form, which is available on our website medicare.highmark.com. Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor, (or other prescriber) or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement**, which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary.

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

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we receive your request.
  - For exceptions, we will give you our answer within 24 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you have not yet received

- We must generally give you our answer **within 72 hours** after we receive your request.
  - For exceptions, we will give you our answer within 72 hours after we receive your doctor's supporting statement. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Deadlines for a standard coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.

- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

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

Section 6.5 How to make a Level 1 appeal

Legal Terms
An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is called an **expedited redetermination.**

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4 of this chapter.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a **fast appeal.**

- **For standard appeals, submit a written request or call us.** Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-550-8722**. Chapter 2 has contact information.
- **We must accept any written request,** including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (medicare.highmark.com). Please be sure to include your name, contact information, and information regarding your claim to assist us in processing your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

- **You can ask for a copy of the information in your appeal and add more information.** You and your doctor may add more information to support your appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to.
  - If we do not give you an answer within 72 hours, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you have not yet received

- For standard appeals, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
  - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within **30 calendar days** after we receive your request.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no. We will also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If you decide to make another appeal, it means your appeal is going to Level 2 of the appeals process.

Section 6.6 How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case.

- If we say no to your Level 1 appeal, the written notice we send you will **include instructions on how to make a Level 2** appeal with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
- **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We will send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file.**
- You have a right to give the independent review organization additional information to support your appeal.

Step 2: The independent review organization reviews your appeal.

Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you have not yet received. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it receives your request.

Step 3: The independent review organization gives you their answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage,** we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It is also called **turning down your appeal**.). In this case, the independent review organization will send you a letter:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

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

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

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

Section 7.1 During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called An Important Message from Medicare about Your Rights. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or 1-800-MEDICARE (1-800-633-4227). (TTY users call 1-877-486-2048).

1. **Read this notice carefully and ask questions if you don't understand it.** It tells you:
   - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
   - Your right to be involved in any decisions about your hospital stay.
   - Where to report any concerns you have about the quality of your hospital care.
   - Your right to **request an immediate review** of the decision to discharge you if you think you are being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time.
2. **You will be asked to sign the written notice to show that you received it and understand your rights.**
   - You or someone who is acting on your behalf will be asked to sign the notice.
   - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date. Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the notice handy so you will have the information about making an appeal (or reporting a concern about quality of care) if you need it.
   - If you sign the notice more than two calendar days before your discharge date, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or 1-800 MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can also get notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

Section 7.2 How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in the Agency Contact Information in the back of this document for a list of SHIP contact information by state.

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

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than midnight the day of your discharge.**

- **If you meet this deadline,** you may stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
- **If you do *not* meet this deadline,** contact us. If you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- Once you request an immediate review of your hospital discharge the Quality Improvement Organization will contact us. By noon of the day after we are contacted, we will give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) or 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. Or you can get a sample notice online at www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im.

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

- If the review organization says *no*, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 7.3 How to make a Level 2 appeal to change your hospital discharge date

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

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

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

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

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

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

If the independent review organization says yes:

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

If the independent review organization says no:

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

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

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

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

Section 8.1 We'll tell you in advance when your coverage will be ending

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

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

Section 8.2 How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process.**
- **Meet the deadlines.**
- **Ask for help if you need it**. If you have questions or need help, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in the Agency Contact Information in the back of this document for a list of SHIP contact information by state.

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

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the Federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts are not part of our plan.

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

How can you contact this organization?

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

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the Notice of Medicare Non-Coverage.
- If you miss the deadline, and you wish to file an appeal, you still have appeal rights. Contact your Quality Improvement Organization, refer to the Agency Contact Information appendix in the back of this document for a list of QIO contact information by state.

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

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

What happens during this review?

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

Step 3: Within one full day after they have all the information they need; the reviewers will tell you their decision.

What happens if the independent reviewers say yes?

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

What happens if the independent reviewers say no?

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

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

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

Section 8.3 How to make a Level 2 appeal to have our plan cover your care for a longer time

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

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

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

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Levels 3, 4, and 5

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

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

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

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

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

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

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

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

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

Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests

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

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal.

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

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal or denies your request to review the appeal, the notice will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

Making complaints

SECTION 10 How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 What kinds of problems are handled by the complaint process?

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • · Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a *fast coverage decision* or a *fast appeal*, and we have said no; you can make a complaint. • You believe we are not meeting the deadlines for coverage decisions or appeals; you can make a complaint.

Complaint	Example
	• You believe we are not meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 How to make a complaint

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

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

- **Calling Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) is usually the first step.** If there's anything else you need to do, Member Services will let you know.
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing..
  - **The Standard Grievance Procedure is as follows:**

  Your initial inquiry should be directed to the Member Services department. If you are dissatisfied with the response to your inquiry, you can ask for a Complaint Review. Your request for a Complaint Review can be made orally or in writing and may include written information from you or any other party of interest. Send your written complaint to:

  Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047

  We will review your written complaint. For complaints regarding such issues as waiting times, physician or pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, we will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the provider, a review of the medical records or ongoing provider monitoring. We will respond in writing within 30 days or as expeditiously as the case requires. Decisions made during the Complaint Review Process are final and binding.

The Expedited or "Fast Grievance" Procedure is as follows:

The expedited grievance procedure is used in the following instances:

- If you disagree with Highmark Senior Health Company invoking a 14-day extension on either an initial determination or a reconsideration.
- If you disagree with the decision not to grant you an expedited initial determination or reconsideration.

Your initial inquiry should be directed to the Member Services department. You may call the number on your member ID card, Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Outside these hours, please call 1-800-550-8722 (TTY users, call 711).

You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest. Highmark Senior Health Company will review your complaint and take the appropriate steps to investigate your complaint. Highmark Senior Health Company will respond in writing within 24 hours from the date the Grievance department receives your complaint.

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

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

Section 10.3 You can also make complaints about quality of care to the Quality Improvement Organization

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

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See the *Agency Contact Information* appendix.

Or

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

Section 10.4 You can also tell Medicare about your complaint

You can submit a complaint about Freedom Blue PPO directly to Medicare. To submit a complaint to Medicare, go to www.Medicare.gov/my/medicare-complaint. You can also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users call 1-877-486-2048.

CHAPTER 10:
Ending membership in our plan

SECTION 1 Ending your membership in our plan

Since your former employer or union/trust fund provides you with your Freedom Blue PPO coverage, the following information may be different for your group. **Please check with your groups benefits administrator before making any changes or ending your membership**.

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

- You might leave our plan because you have decided that you *want* to leave. Sections 2 and 3 provide information on ending your membership voluntarily.
- There are also limited situations where we are required to end your membership. Section 5 tells you about situations when we must end your membership.

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

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

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

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

- **The Open Enrollment Period** is from **October 15 to December 7**.
- **Choose to keep your current coverage or make changes to your coverage for the upcoming year.** If you decide to change to a new plan, you can choose any of the following types of plans:
  - Another Medicare health plan, with or without drug coverage,
  - Original Medicare *with* a separate Medicare drug plan,
  - *-or-* Original Medicare *without* a separate Medicare drug plan,
    - If you choose this option and receive Extra Help, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

- **Your membership will end in our plan** when your new plan's coverage starts on January 1.

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

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

- **The Medicare Advantage Open Enrollment Period** is from January 1 to March 31 and also for new Medicare beneficiaries who are enrolled in an MA plan, from the month of entitlement to Part A and Part B until the last day of the 3rd month of entitlement.
- **During the Medicare Advantage Open Enrollment Period** you can:
  - Switch to another Medicare Advantage Plan with or without drug coverage.
  - Disenroll from our plan and get coverage through Original Medicare. If you switch to Original Medicare during this period, you can also join a separate Medicare drug plan at the same time.
- **Your membership will end** on the first day of the month after you enroll in a different Medicare Advantage plan or we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

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

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

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

- Usually, when you move
- If you have Medicaid
- If you're eligible for Extra Help paying for Medicare drug coverage
- If we violate our contract with you
- If you're getting care in an institution, such as a nursing home or long-term care (LTC) hospital

- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **Note:** If you're in a drug management program, you may not be able to change plans. Chapter 5, Section 10 tells you more about drug management programs.

Enrollment time periods vary depending on your situation.

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

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

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 days or more in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Your membership will usually end on the first day of the month after we get your request to change our plan.

If you get Extra Help from Medicare to pay your drug coverage costs: If you switch to Original Medicare and don't enroll in a separate Medicare drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Section 2.4 Get more information about when you can end your membership

If you have questions about ending your membership you can:

- **Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service)**
- Find the information in the ***Medicare & You 2026*** handbook.
- Call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048

SECTION 3 How to end your membership in our plan

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

To switch from our plan to:	Here's what to do:
Another Medicare health plan.	• Enroll in the new Medicare health plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.

To switch from our plan to:	Here's what to do:
Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare drug plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service) if you need more information on how to do this. • You can also call **Medicare** at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users call 1-877-486-2048. • You'll be disenrolled from Freedom Blue PPO when your coverage in Original Medicare starts.

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

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

- **Continue to use our network providers to receive medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

SECTION 5 Freedom Blue PPO must end our plan membership in certain situations

Freedom Blue PPO must end your membership in our plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than twelve (12) months.
    - If you move or take a long trip, call Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated (go to prison).
- If you are no longer a United States citizen or lawfully present in the United States.

- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums (if applicable) for three months.
    - We must notify you in writing that you have three months to pay the plan premium before we end your membership.
- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose drug coverage.

If you have questions or want more information on when we can end your membership, call Member Services at 1-800-550-8722 (TTY users should call 711 National Relay Service).

Section 5.1 We can't ask you to leave our plan for any health-related reason

Freedom Blue PPO } isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048.

Section 5.2 You have the right to make a complaint if we end your membership in our plan

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

CHAPTER 11: Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

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

If you have a disability and need help with access to care, call us at Member Services 1-800-550-8722 (TTY users should call 711 National Relay Service). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Freedom Blue PPO, as a Medicare Advantage Organization, will exercise the same rights of

recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

NOTICE OF MEDICARE SECONDARY PAYER SUBROGATION RIGHTS

As a Medicare Advantage Plan that provides your federal Medicare benefits, this Plan has the right and responsibility to recover for covered Medicare services for which Medicare is not the primary payer. This means that the benefits provided under this Plan are secondary to any other sources of payment including but not limited to uninsured and underinsured motorist coverage, any no-fault insurance, medical payments coverage (auto, homeowners or otherwise), individual or group health insurance, workers compensation, any other insurance or any individual or other liable party(including companies, corporations or other entities).

This Medicare Advantage Plan conditionally provides payments until another source is identified, available and determined to be responsible for payment, whether through settlement, judgment, arbitration award or verdict. A Medicare Advantage Plan, pursuant to 42 C.F.R §422.108 and 423.462, has the same rights of recovery exercised by traditional Medicare through Federal Law and supersedes any State law. In addition to the rights granted under Federal law, this Plan asserts contractual rights of recovery through subrogation and reimbursement.

Reimbursement
This section applies when a Covered Person, or the legal representative, estate or heirs of the Covered Person (sometimes collectively referred to as the "Covered Person") recovers damages, by settlement, verdict or otherwise (including wrongful death and/or survivorship cases) for an injury, sickness or other condition. If the Covered Person has made, or in the future may make, such a recovery, including a recovery from any insurance carrier, the Plan will not cover either the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness. These benefits are specifically excluded.

However, if the Plan does advance moneys or provide care for such an injury, sickness or other condition, the Covered Person shall promptly convey moneys or other property from any settlement, arbitration award, verdict or any insurance proceeds or monetary recovery from any party received by the Covered Person (or by the legal representatives, estate or heirs of the Covered Person), to the Plan for the reasonable value of the medical benefits advanced or provided by the Plan to the Covered Person, regardless of whether or not (1) the Covered Person has been fully compensated, or "made-whole" for his/her loss; (2) liability for payment is admitted by the Covered Person or any other party; or (3) the recovery by the Covered Person is itemized or called anything other than a recovery for medical expenses incurred.

If a recovery is made, the Plan shall have first priority in payment over the Covered Person, or any other party, to receive reimbursement of the benefits advanced on the Covered Person's behalf. This reimbursement shall be from any recovery made by the Covered Person, and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation

settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties. Likewise, the reimbursement provision specifically applies to recoveries obtained from wrongful death and/or survivorship cases. The Plan's first priority right shall apply to all recoveries whether or not the amount constitutes a full or partial recovery of the Covered Person's damages.

In order to secure the rights of the Plan under this section, and because of the Plan's advancement of benefits, the Covered Person hereby (1) acknowledges that the Plan shall have a first priority lien against the proceeds of any such settlement, arbitration award, verdict, or any other amounts received by the Covered Person; and (2) assigns to the Plan any benefits the Covered Person may have under any automobile policy or other coverage, to the extent of the Plan's claim for reimbursement. The Covered Person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such priority or reimbursement right, or to effect such assignment of benefits. By accepting any benefits advanced by the Plan under this section, the Covered Person acknowledges that any proceeds of settlement or judgment, including a Covered Person's claim to such proceeds held by another person, held by the Covered Person or by another, are being held for the benefit of the Plan under these provisions. The Covered Person agrees that the proceeds subject to the plan's lien are Plan assets and that the Covered Person will hold such assets as a trustee for the Plan's benefit and shall remit to the Plan, or its representative, such assets upon request. If represented by counsel, the Covered Person agrees to direct such counsel to hold the proceeds subject to the Plan's lien in trust and to remit such funds to the Plan, or its representative, upon request. Should the Covered Person violate any portion of this section, the Plan shall have a right to offset future benefits otherwise payable under this plan to the extent of the value of the benefits advanced under this section to the extent not recovered by the plan. The Plan may also seek double damages in a private action.

The Covered Person shall cooperate with the Plan and its agents, and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan's right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The Covered Person shall not take any action that prejudices the Plan's rights of reimbursement and consents to the right of the Plan, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any settlement to enforce the Plan's rights under this section, and/or to set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing. No Covered Person hereunder shall incur any expenses on behalf of the Plan in pursuit of the Plan's rights hereunder. Specifically, no court costs or attorney's fees may be deducted from the Plan's recovery without the express written consent of the Plan. Any so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall not defeat this right.

In cases of occupational illness or injury, the Plan's recovery rights shall apply to all sums recovered, regardless of whether the illness or injury is deemed compensable under any workers' compensation or other coverage. Any award or compromise settlement, including any lump-sum

settlement, shall be deemed to include the Plan’s interest and the Plan shall be reimbursed in first priority from any such award or settlement.

The Plan shall recover the full amount of benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of Covered Person, whether under comparative negligence or otherwise.

Subrogation

This section applies when another party is, or may be considered, liable for a Covered Person's injury, sickness or other condition (including insurance carriers who are so financially liable) and the Plan has advanced benefits.

In consideration for the advancement of benefits, the Plan is subrogated to all of the rights of the Covered Person against any party liable for the Covered Person's injury or illness, or is or may be liable for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the value of the medical benefits advanced to the Covered Person under the Plan. The Plan may assert this right independently of the Covered Person. This right includes, but is not limited to, the Covered Person’s rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, or other insurance, as well as the Covered Person’s rights under the Plan to bring an action to clarify his or her rights under the Plan. The Plan is not obligated in any way to pursue this right independently or on behalf of the Covered Person, but may choose to pursue its rights to reimbursement under the Plan, at its sole discretion.

The Covered Person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the Covered Person enters into litigation or settlement negotiations regarding the obligations of other parties, the Covered Person must not prejudice, in any way, the subrogation rights of the Plan under this section. In the event that the Covered Person fails to cooperate with this provision, including executing any documents required herein, the Plan may, in addition to remedies provided elsewhere in the Plan and/or under the law, set off from any future benefits otherwise payable under the Plan the value of benefits advanced under this section to the extent not recovered by the Plan.

The Plan’s subrogation right is a first priority right and must be satisfied in full prior to any other claim of the Covered Person or his/her representative(s), regardless of whether the Covered Person is fully compensated for his/her damages. The costs of legal representation of the Plan

in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Covered Person shall be borne solely by the Covered Person.

SECTION 4 Notice about how we determine if a technology is experimental

Medical experts are constantly searching for and testing new equipment and methods for treating health conditions. In turn, health care plans like Highmark Senior Health Company must evaluate these technologies to determine if they are covered by your Freedom Blue PPO plan.

Highmark Senior Health Company believes that decisions for evaluating new technologies, new applications of existing technologies and devices should be made by medical professionals. But Highmark Senior Health Company also honors decisions made by regulatory bodies, such as the Centers for Medicare & Medicaid Services (CMS). For Medicare Advantage plans like Freedom Blue PPO, CMS requires health plans to follow National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs). Sometimes NCDs or LCDs disagree with the health plan's decision. If the service is being provided to a Medicare Advantage member, the health plan must abide by the regulations and guidance of the NCDs or LCDs.

To stay current and patient-responsive, these reviews are ongoing and all encompassing. They consider factors such as product efficiency, safety and effectiveness. If the technology passes the review process, the Medical Affairs Committee recommends that it be considered an acceptable medical practice and a covered benefit. Technology that does not pass the review is usually considered "experimental/investigative" and not covered by the health plan. However, it may be re-evaluated in the future.

We recognize that situations may occur when you choose to pursue experimental or investigative treatment. If you are concerned that a service you will receive may be considered experimental or investigational, you, the hospital and/or the professional provider may contact Freedom Blue PPO to determine if the service will be covered.

SECTION 5 Notice about how we determine if a drug is experimental

A process similar to the one outlined above is followed for evaluating new drugs. The Pharmacy and Therapeutics (P & T) Committee assesses new drugs based on national and international data, research that is currently underway and expert opinion from leading clinicians. The P & T Committee consists of at least one Highmark Senior Health Company employed pharmacist and/or medical director, five board-certified, actively practicing network physicians and two licensed, registered pharmacists currently providing clinical pharmacy services within the Highmark Senior Health Company service area. At the committee's discretion, advice, support and consultation may also be sought from physician subcommittees in the following specialties: cardiology, dermatology, endocrinology, hematology/oncology, obstetrics/gynecology, ophthalmology, psychiatry, infectious disease, neurology, gastroenterology and urology. Issues

that are addressed during the review process include clinical efficacy, unique value, safety, patient compliance, local physician and specialist input, and pharmacoeconomic impact. After the review is complete, the P & T Committee makes recommendations.

SECTION 6 Notice about what you need to know about your coverage

Have you ever wondered why your health care benefits pay for certain medical services but may not cover other care? Highmark Senior Health Company looks at two important things:

- **Your specific benefit plan and what it covers.** You can find out more about what's covered under your benefits by referring to this *Evidence of Coverag*e.
- **Whether the specific procedure, therapy, medication or equipment is "medically necessary."** Highmark Senior Health Company and the companies that work with us determine if something is "medically necessary" by using nationally recognized guidelines, our own medical policy, Medicare guidelines and specific government guidelines that may apply. The outside companies we work with specialize in certain areas, such as radiology or prescription drugs. All of these companies must meet certain standards, follow Highmark Senior Health Company policy, and agree to allow us to review their work every year.

By using this approach to provide coverage, we ensure that all members receive medically appropriate health care and are treated consistently.

No Rewards For Denying Coverage

Highmark Senior Health Company does not reward employees, doctors, other health care providers or anyone for denying coverage. We also don't give rewards to anyone who is reviewing care—or making decisions about what's covered—to encourage them to deny coverage.

Who Reviews Requests?

If you or your doctor requests a service that needs to be approved, this request goes to a nurse in our Medical Management & Policy Department. If the nurse cannot approve the request, it is forwarded to a Highmark Senior Health Company physician for review. The physician may contact your physician to discuss the request and get more information. After all the medical information has been reviewed, a decision is made.

Need More Information?

Both you and your physician have the right to know the source of the criteria that we use to make decisions about what is covered and what isn't.

- Your physician may request this information by calling 1-800-452-8507 for medical or surgical decisions, and 1-800-258-9808 for a behavioral health decision.

You may also request information about your coverage or benefits by calling Member Services.

SECTION 7 Notice about coordination of benefits

If you are covered under another insurance carrier's program in addition to Freedom Blue PPO, duplicate coverage exists. If you have duplicate coverage, it must be determined which insurance company has primary liability – that is, which coverage will pay first for your eligible health care services. The process of determining this is called "coordination of benefits."

If you are age 65 and older and you have coverage under an employer group plan, based on your current employment or that of your spouse, you must use the benefits of that plan first. Similarly, if you have Medicare based on disability and are covered under an employer plan, either through your own current employment or that of a family member, you must use the benefits of that plan first. In both cases, you will receive only those Freedom Blue PPO benefits that are not covered by the employer group plan.

CHAPTER 12: Definitions

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

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

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

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

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (Go to "**Original Biological Product**" and "**Biosimilar**").

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

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2100 for Part D covered drugs during the covered year.

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

Chronic-Care Special Needs Plan - C-SNPs are SNPs that restrict enrollment to MA eligible people who have specific severe and chronic diseases.

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

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

Complaint – The formal name for making a complaint is filing a grievance. The complaint process is used only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

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

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

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called coverage decisions in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard

prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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

Daily cost-sharing rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care before our plan pays.

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

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

Dually Eligible Individual – A person who is eligible for Medicare and Medicaid coverage.

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

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

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

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

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

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

Generic Drug – A prescription drug that is approved by the FDA as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

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

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

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

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

Income Related Monthly Adjustment Amount (IRMAA) –If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

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

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

In-Network Maximum Out-of-Pocket Amount – The most you'll pay for covered Part A and Part B services gotten from network (preferred) providers. After you have reached this limit, you won't have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. In addition to the maximum out-of-pocket amount for in-network covered Part A and Part B medical services, your plan may also have a maximum out-of-pocket amount for certain types of services.

Institutional Special Needs Plan (I-SNP) – I-SNPs restrict enrollment to MA eligible people who live in the community but need the level of care a facility offers, or who live (or are expected to live) for at least 90 days straight in certain long-term facilities. I-SNPs include the following types of plans: Institutional-equivalent SNPs (IE-SNPs) Hybrid Institutional SNPs (HI-SNPs), and Facility-based Institutional SNPs (FI-SNPs).

Institutional-Equivalent Special Needs Plan (IE-SNP) – An IE-SNP restricts enrollment to MA eligible people who live in the community but need the level of care a facility offers.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Low Income Subsidy (LIS) –Go to Extra Help.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan’s full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

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

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

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

Medicare Advantage Open Enrollment Period – The time period from January 1 to March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan or get coverage through Original Medicare. If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription

drug plan at that time. The Medicare Advantage Open Enrollment Period is also available for a 3-month period after a person is first eligible for Medicare.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be i) an HMO, ii) a PPO, iii) a Private Fee-for-Service (PFFS) plan, or iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called Medicare Advantage Plans with Prescription Drug Coverage.

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

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

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

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

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

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

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

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. Network providers have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called plan providers.

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

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

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

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

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

Part C –Go to Medicare Advantage (MA) Plan.

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

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

and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets prior authorization from our plan. In a PPO, you don't need prior authorization to get out-of-network services. However, you may want to check with our plan before getting services from out-of-network providers to confirm that the service is covered by our plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Medical Benefits Chart appendix.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

Quantity Limits – A management tool that is designed to limit the use of a drug for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan –A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who live in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we'll cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

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

Discrimination is Against the Law

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Plan will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Plan will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with:

Civil Rights Coordinator

P.O. Box 22492

Pittsburgh, PA 15222

Phone: 1-866-286-8295 (TTY: 711), Fax: 412-544-2475

Email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

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

U.S. Department of Health and Human Services

200 Independence Avenue, SW

Room 509F, HHH Building

Washington, D.C. 20201

Phone: 1-800-368-1019, 800-537-7697 (TDD)
Complaint forms are available at www.hhs.gov/ocr/office/file/index.html

Multi-Language Insert
Multi-language Interpreter Services

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge. Call the number on the back of your ID card (TTY: 711) for help.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo. Llame al número que figura al dorso de su tarjeta de identificación (TTY: 711) si necesita ayuda.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich. Wählen Sie hierfür bitte die Nummer auf der Rückseite Ihrer Ausweiskarte (TTY: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou. Rele nimewo ki sou do Kat ID w lan (TTY: 711) pou jwenn èd.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи). Для получения помощи позвоните по номеру, указанному на обратной стороне вашей идентификационной карты (TTY: 711).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili. Per assistenza, chiami il numero riportato sul retro della Sua tessera di identificazione (TTY: 711).

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles. Veuillez appeler le numéro qui se trouve au verso de votre carte d'identification (TTY : 711) pour obtenir de l'aide.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ńí àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ̀ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìrááyè si wà pẹlu lọ́fẹ̀ẹ́. Pe nọmba tó wà lẹhin kaádì ìdánimọ rẹ (TTY: 711) fún iranlọwọ.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל. רופט פאר הילף (TTY: 711) דעם נומער אויף די אנדערע זייט פון אייער אידענטיטעט קארטל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة. اتصل على الرقم المدوّن على ظهر بطاقة هويتك للحصول على المساعدة (TTY: 711).

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。如需帮助，请拨打您的 ID 卡背面的号码（听障人士专用号码： 711）。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે. મદદ માટે તમારા આઈડી કાર્ડની પાછળ આપેલા નંબર (TTY: 711) પર કૉલ કરો.
CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận. Vui lòng gọi số điện thoại trên mặt sau của thẻ nhận dạng của quý vị (TTY: 711) để được trợ giúp.

ध्यान दनिुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्। मद्दतको लागि तपाईंको ID कार्डको पछाडिको नम्बरमा कल गर्नुहोस् (TTY: 711)।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं। सहायता के लिए अपने पहचान कार्ड के पीछे लिखे नंबर (TTY: 711) पर कॉल करें।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이 필요하시면 ID 카드 뒷면에 있는 번호로 전화하십시오(TTY: 711).

Blue Cross Blue Shield Association
Network Sharing Counties by State

The following 24 states and 2 territories below participate BCBSA Medicare Advantage PPO providers in all counties:

Alabama	**Hawaii**	**Minnesota**	**North Dakota**	**Tennessee**
Connecticut	**Indiana**	**New Hampshire**	**Ohio**	**Vermont**
Delaware	**Kentucky**	**New Jersey**	**Pennsylvania**	**Virginia**
District of Columbia*	**Louisiana**	**New York**	**Puerto Rico**	**West Virginia**
Florida	**Maine**	**North Carolina**	**Rhode Island**	**Wisconsin**
	Michigan			

The following 24 states below participate in the BCBSA Medicate Advantage PPO Providers only in the counties listed:

State	County
AZ	MARICOPA
AZ	PIMA
CA	ALAMEDA
CA	ALPINE
CA	AMADOR
CA	BUTTE
CA	CALAVERAS
CA	CALOUSA
CA	COLUSA
CA	CONTRA COSTA
CA	EL DORADO
CA	FRESNO
CA	GLENN
CA	HUMBOLDT
CA	IMPERIAL
CA	INYO
CA	KERN
CA	KINGS
CA	LAKE
CA	LASSEN
CA	LOS ANGELES
CA	MADERA
CA	MARIN
CA	MARIPOSA

State	County
CA	MENDOCINO
CA	MERCED
CA	MONO
CA	MONTEREY
CA	NAPA
CA	NEVADA
CA	ORANGE
CA	PLACER
CA	PLUMAS
CA	RIVERSIDE
CA	SACRAMENTO
CA	SAN BENITO
CA	SAN BERNARDINO
CA	SAN DIEGO
CA	SAN FRANCISCO
CA	SAN JOAQUIN
CA	SAN LUIS OBISPO
CA	SAN MATEO
CA	SANTA BARABRA
CA	SANTA CLARA
CA	SANTA CRUZ
CA	SHASTA
CA	SIERRA
CA	SISKIYOU

State	County
CA	SOLANO
CA	SONOMA
CA	STANISLAUS
CA	SUTTER
CA	TEHAMA
CA	TRINITY
CA	TULARE
CA	TUOLUMNE
CA	VENTURA
CA	YOLO
CA	YUBA
CO	ADAMS
CO	ARAPAHOE
CO	BENT
CO	BOULDER
CO	BROOMFIELD
CO	CHAFFEE
CO	CLEAR CREEK
CO	CONEJOS
CO	COSTILLA
CO	CROWLEY
CO	CUSTER
CO	DELTA
CO	DENVER

State	County
CO	DOLORES
CO	DOUGLAS
CO	EAGLE
CO	EL PASO
CO	ELBERT
CO	FREMONT
CO	GARFIELD
CO	GILPIN
CO	GRAND
CO	GUNNISON
CO	HINSDALE
CO	HUEFRANO
CO	JACKSON
CO	JEFFERSON
CO	LAKE
CO	LARIMER
CO	LAS ANIMAS
CO	LINCOLN
CO	MESA
CO	MINERAL
CO	MOFFAT
CO	MONTROSE
CO	MORGAN
CO	OURAY
CO	PARK
CO	PITKIN
CO	PUEBLO
CO	RIO BLANCO
CO	RIO GRANDE
CO	ROUTT
CO	SAGUCHE
CO	SAN JUAN
CO	SAN MIGUEL
CO	SUMMIT
CO	TELLER
CO	WASHINGTON
CO	WELD
GA	APPLING
GA	ATKINSON
GA	BACON
GA	BAKER
GA	BALDWIN

State	County
GA	BANKS
GA	BARROW
GA	BARTOW
GA	BEN HILL
GA	BERRIEN
GA	BIBB
GA	BLECKLEY
GA	BRANTLEY
GA	BROOKS
GA	BRYAN
GA	BULLOCH
GA	BURKE
GA	BUTTS
GA	CALHOUN
GA	CAMDEN
GA	CANDLER
GA	CARROLL
GA	CATOOSA
GA	CHARLTON
GA	CHATHAM
GA	CHATTAHOOCHEE
GA	CHATTOOGA
GA	CHEROKEE
GA	CLARKE
GA	CLAY
GA	CLAYTON
GA	CLINCH
GA	COBB
GA	COFFEE
GA	COLQUITT
GA	COLUMBIA
GA	COOK
GA	COWETA
GA	CRAWFORD
GA	CRISP
GA	DADE
GA	DAWSON
GA	DECATUR
GA	DEKALB
GA	DODGE
GA	DOOLY
GA	DOUGLAS

State	County
GA	ECHOLS
GA	EFFINGHAM
GA	ELBERT
GA	EMANUEL
GA	EVANS
GA	FANNIN
GA	FAYETTE
GA	FLOYD
GA	FORSYTH
GA	FRANKLIN
GA	FULTON
GA	GILMER
GA	GLASCOCK
GA	GLYNN
GA	GORDON
GA	GRADY
GA	GREENE
GA	GWINNETT
GA	HABERSHAM
GA	HALL
GA	HANCOCK
GA	HARALSON
GA	HARRIS
GA	HART
GA	HEARD
GA	HENRY
GA	HOUSTON
GA	IRWIN
GA	JACKSON
GA	JASPER
GA	JEFF DAVIS
GA	JEFFERSON
GA	JENKINS
GA	JOHNSON
GA	JONES
GA	LAMAR
GA	LANIER
GA	LAURENS
GA	LEE
GA	LIBERTY
GA	LINCOLN
GA	LONG

State	County
GA	LOWDNES
GA	LUMPKIN
GA	MACON
GA	MADISON
GA	MARION
GA	MCDUFFIE
GA	McINTOSH
GA	MERIWETHER
GA	MILLER
GA	MITCHELL
GA	MONROE
GA	MONTGOMERY
GA	MORGAN
GA	MURRAY
GA	MUSCOGEE
GA	NEWTON
GA	OCONEE
GA	OGLETHORPE
GA	PAULDING
GA	PEACH
GA	PICKENS
GA	PIERCE
GA	PIKE
GA	POLK
GA	PULASKI
GA	PUTNAM
GA	QUITMAN
GA	RABUN
GA	RANDOLPH
GA	RICHMOND
GA	ROCKDALE
GA	SCHLEY
GA	SCREVEN
GA	SEMINOLE
GA	SPALDING
GA	STEPHENS
GA	STEWART
GA	SUMTER
GA	TALBOT
GA	TALIAFERRO
GA	TATTNALL
GA	TAYLOR

State	County
GA	TELFAIR
GA	TERRELL
GA	THOMAS
GA	TIFT
GA	TOOMBS
GA	TOWNS
GA	TREUTLEN
GA	TROUP
GA	TURNER
GA	TWIGGS
GA	UNION
GA	UPSON
GA	WALKER
GA	WALTON
GA	WARE
GA	WARREN
GA	WASHINGTON
GA	WAYNE
GA	WEBSTER
GA	WHEELER
GA	WHITE
GA	WILCOX
GA	WILKES
GA	WILKINSON
GA	WORTH
IA	ADAIR
IA	ADAMS
IA	ALLAMAKEE
IA	APPANOOSE
IA	AUDUBON
IA	BENTON
IA	BLACK HAWK
IA	BOONE
IA	BREMER
IA	BUCHANAN
IA	BUENA VISTA
IA	BUTLER
IA	CALHOUN
IA	CARROLL
IA	CASS
IA	CEDAR
IA	CERRO GORDO

State	County
IA	CHEROKEE
IA	CHICKASAW
IA	CLARKE
IA	CLAY
IA	CLAYTON
IA	CLINTON
IA	CRAWFORD
IA	DALLAS
IA	DAVIS
IA	DECATUR
IA	DELAWARE
IA	DES MOINES
IA	DICKINSON
IA	EMMET
IA	FAYETTE
IA	FLOYD
IA	FRANKLIN
IA	FREMONT
IA	GREENE
IA	GRUNDY
IA	GUTHRIE
IA	HAMILTON
IA	HANCOCK
IA	HARDIN
IA	HARRISON
IA	HENRY
IA	HOWARD
IA	HUMBOLDT
IA	IDA
IA	IOWA
IA	JACKSON
IA	JASPER
IA	JEFFERSON
IA	JOHNSON
IA	JONES
IA	KEOKUK
IA	KOSSUTH
IA	LEE
IA	LINN
IA	LOUISA
IA	LUCAS
IA	LYON

State	County
IA	MADISON
IA	MAHASKA
IA	MARION
IA	MARSHALL
IA	MILLS
IA	MITCHELL
IA	MONONA
IA	MONROE
IA	MONTGOMERY
IA	MUSCATINE
IA	O'BRIEN
IA	OSCEOLA
IA	PAGE
IA	PALO ALTO
IA	PLYMOUTH
IA	POCAHONTAS
IA	POLK
IA	POTTAWATTAMIE
IA	POWESHIEK
IA	RINGGOLD
IA	SAC
IA	SCOTT
IA	SHELBY
IA	SIOUX
IA	STORY
IA	TAMA
IA	TAYLOR
IA	UNION
IA	VAN BUREN
IA	WAPELLO
IA	WARREN
IA	WASHINGTON
IA	WAYNE
IA	WEBSTER
IA	WINNEBAGO
IA	WINNESHIEK
IA	WOODBURY
IA	WORTH
IA	WRIGHT
ID	ADA
ID	ADAMS
ID	BANNOCK

State	County
ID	BENEWAH
ID	BINGHAM
ID	BLAINE
ID	BOISE
ID	BONNER
ID	BONNEVILLE
ID	BOUNDARY
ID	CANYON
ID	CASSIA
ID	CLARK
ID	ELMORE
ID	FREMONT
ID	GEM
ID	GOODING
ID	JEFFERSON
ID	JEROME
ID	KOOTENAI
ID	LATAH
ID	LINCOLN
ID	MADISON
ID	MINIDOKA
ID	NEZ PERCE
ID	OWYHEE
ID	PAYETTE
ID	POWER
ID	SHOSHONE
ID	TWIN FALLS
ID	VALLEY
ID	WASHINGTON
IL	ADAMS
IL	ALEXANDER
IL	BOND
IL	BOONE
IL	BROWN
IL	BUREAU
IL	CALHOUN
IL	CARROLL
IL	CASS
IL	CHRISTIAN
IL	CLARK
IL	CLAY
IL	CLINTON

State	County
IL	COLES
IL	COOK
IL	CRAWFORD
IL	CUMBERLAND
IL	DEKALB
IL	DEWITT
IL	DOUGLAS
IL	DUPAGE
IL	EDGAR
IL	EDWARDS
IL	EFFINGHAM
IL	FAYETTE
IL	FORD
IL	FRANKLIN
IL	FULTON
IL	GALLATIN
IL	GREENE
IL	GRUNDY
IL	HAMILTON
IL	HANCOCK
IL	HARDIN
IL	HENDERSON
IL	HENRY
IL	IROQUOIS
IL	JACKSON
IL	JASPER
IL	JEFFERSON
IL	JERSEY
IL	JOHNSON
IL	KANE
IL	KANKAKEE
IL	KENDALL
IL	KNOX
IL	LA SALLE
IL	LAKE
IL	LAWRENCE
IL	LEE
IL	LIVINGSTON
IL	LOGAN
IL	MACON
IL	MACOUPIN
IL	MADISON

State	County
IL	MARION
IL	MARSHALL
IL	MASON
IL	MCDONOUGH
IL	MCHENRY
IL	MCLEAN
IL	MENARD
IL	MERCER
IL	MONROE
IL	MONTGOMERY
IL	MORGAN
IL	MOULTRIE
IL	OGLE
IL	PEORIA
IL	PERRY
IL	PIATT
IL	PIKE
IL	POPE
IL	PULASKI
IL	PUTNAM
IL	RANDOLPH
IL	RICHLAND
IL	ROCK ISLAND
IL	SALINE
IL	SANGAMON
IL	SCHUYLER
IL	SCOTT
IL	SHELBY
IL	ST. CLAIR
IL	STARK
IL	STEPHENSON
IL	TAZEWELL
IL	UNION
IL	WARREN
IL	WASHINGTON
IL	WAYNE
IL	WHITE
IL	WHITESIDE
IL	WILL
IL	WILLIAMSON
IL	WINNEBAGO
IL	WOODFORD

State	County
KS	BULTLER
KS	CHASE
KS	COFFEE
KS	COWLEY
KS	DICKINSON
KS	DOUGLAS
KS	FRANKLIN
KS	GEARY
KS	HARVEY
KS	JACKSON
KS	JEFFERSON
KS	JOHNSON
KS	KINGMAN
KS	LEAVENWORTH
KS	LINN
KS	LYON
KS	MARION
KS	MCPHERSON
KS	MIAMI
KS	MORRIS
KS	OSAGE
KS	POTTAWATOMIE
KS	RENO
KS	RILEY
KS	SEDGWICK
KS	SHAWNEE
KS	SUMNER
KS	WABAUNSEE
KS	WYANDOTTE
MA	BARNSTABLE
MA	BRISTOL
MA	ESSEX
MA	FRANKLIN
MA	HAMPDEN
MA	HAMPSHIRE
MA	MIDDLESEX
MA	NORFOLK
MA	PLYMOUTH
MA	SUFFOLK
MA	WORCESTER
MD	ANNE ARUNDEL*
MD	BALTIMORE CITY*

State	County
MD	BALTIMORE*
MD	CAROLINE
MD	CECIL
MD	CARROLL*
MD	CHARLES
MD	DORCHESTER
MD	FREDERICK
MD	HARFORD*
MD	KENT
MD	HOWARD
MD	MONTGOMERY
MD	PRINCE GEORGE'S*
MD	SOMERSET
MD	QUEEN ANNE
MD	TALBOT
MD	WASHINGTON
MD	WICOMICO
MD	WORCESTER
MO	ADAIR
MO	ANDREW
MO	AUDRIAN
MO	BARRY
MO	BARTON
MO	BENTON
MO	Bates
MO	BOLLINGER
MO	BOONE
MO	Buchanan
MO	BUTLER
MO	CALLAWAY
MO	CAMDEN
MO	CAPE GIRADEAU
MO	CARROLL
MO	CARTER
MO	Cass
MO	CEDAR
MO	CHARITON
MO	CHRISTIAN
MO	CLARK
MO	CLAY
MO	Clinton

State	County
MO	COLE
MO	COOPER
MO	CRAWFORD
MO	DADE
MO	DALLAS
MO	DENT
MO	DOUGLAS
MO	DUNKLIN
MO	FRANKLIN
MO	GASCONADE
MO	GREENE
MO	Henry
MO	HICKORY
MO	HOWARD
MO	HOWELL
MO	IRON
MO	Jackson
MO	JASPER
MO	JEFFERSON
MO	Johnson
MO	KNOX
MO	LACLEDE
MO	Lafayette
MO	LAWRENCE
MO	LEWIS
MO	LINCOLN
MO	LINN
MO	MACON
MO	MADISON
MO	MARIES
MO	MARION
MO	MCDONALD
MO	MILLER
MO	MISSISSIPPI
MO	MONITEAU
MO	MONROE
MO	MONTGOMERY
MO	MORGAN
MO	NEW MADRID
MO	NEWTON
MO	OREGON
MO	OSAGE

State	County
MO	OZARK
MO	PEMISCOT
MO	PERRY
MO	PETTIS
MO	PHELPS
MO	PIKE
MO	Platte
MO	POLK
MO	PULASKI
MO	PUTNAM
MO	RALLAS
MO	RANDOLPH
MO	Ray
MO	REYNOLDS
MO	RIPLEY
MO	SAINT CHARLES
MO	SAINT FRANCOIS
MO	SAINT LOUIS
MO	SAINT LOUIS CITY
MO	SALINE
MO	SCHUYLER
MO	SCOTLAND
MO	SCOTT
MO	SHANNON
MO	SHELBY
MO	ST GENEVIEVE
MO	St. Clair
MO	STODDARD
MO	STONE
MO	SULLIVAN
MO	TANEY
MO	TEXAS
MO	Vernon
MO	WARREN
MO	WASHINGTON
MO	WAYNE
MO	WEBSTER
MO	WRIGHT
MS	CLAY
MS	HANCOCK
MS	HARRISON
MS	HINDS

State	County
MS	ITAWAMBA
MS	JACKSON
MS	LEE
MS	MADISON
MS	MONROE
MS	PONTOTOC
MS	RANKIN
MS	STONE
MS	TOSHOMINGO
MS	UNION
MT	Beaverhead
MT	Broadwater
MT	Cascade
MT	Deer Lodge
MT	Fergus
MT	Flathead
MT	Gallatin
MT	Granite
MT	Hill
MT	Jefferson
MT	Lake
MT	Lewis and Clark
MT	Lincoln
MT	Madison
MT	Missoula
MT	Park
MT	Powell
MT	Ravalli
MT	Stillwater
MT	Yellowstone
NE	DODGE
NE	ADAMS
NE	ANTELOPE
NE	ARTHUR
NE	BLAINE
NE	BOONE
NE	BUFFALO
NE	BURT
NE	BUTLER
NE	CASS
NE	CEDAR
NE	CHASE

State	County
NE	CLAY
NE	COLFAX
NE	CUMING
NE	CUSTER
NE	DAWSON
NE	DEUEL
NE	DOUGLAS
NE	DUNDY
NE	FILLMORE
NE	FRANKLIN
NE	FRONTIER
NE	FURNAS
NE	GAGE
NE	GARDEN
NE	GARFIELD
NE	GOSPER
NE	GRANT
NE	GREELEY
NE	HALL
NE	HAMILTON
NE	HARLAN
NE	HAYES
NE	HITCHCOCK
NE	HOLT
NE	HOOKER
NE	HOWARD
NE	JEFFERSON
NE	JOHNSON
NE	KEARNEY
NE	KEITH
NE	KNOX
NE	LANCASTER
NE	LINCOLN
NE	LOGAN
NE	LOUP
NE	MADISON
NE	MCPHERSON
NE	MERRICK
NE	NANCE
NE	NEMAHA
NE	NUCKOLLS
NE	OTOE

State	County
NE	PAWNEE
NE	PERKINS
NE	PHELPS
NE	PIERCE
NE	PLATTE
NE	POLK
NE	RED WILLOW
NE	SALINE
NE	SARPY
NE	SAUNDERS
NE	SEWARD
NE	SHERMAN
NE	STANTON
NE	THAYER
NE	THOMAS
NE	THURSTON
NE	VALLEY
NE	WASHINGTON
NE	WAYNE
NE	WEBSTER
NE	WHEELER
NE	YORK
NM	BERNALILLO
NM	CATRON
NM	CHAVES
NM	CIBOLA
NM	COLFAX
NM	CURRY
NM	DEBACA
NM	DONA ANA
NM	GRANT
NM	GUADALUPE
NM	HARDING
NM	LINCOLN
NM	LOSALAMOS
NM	LUNA
NM	MCKINLEY
NM	MORA
NM	OTERO
NM	QUAY
NM	RIOARRIBA
NM	ROOSEVELT

State	County
NM	SANDOVAL
NM	SANJUAN
NM	SANMIGUEL
NM	SANTA FE
NM	SIERRA
NM	SOCORRO
NM	TAOS
NM	TORRANCE
NM	VALENCIA
NV	CARSON CITY
NV	CHURCHILL
NV	CLARK
NV	DOUGLAS
NV	ELKO
NV	ESMERALDA
NV	LYON
NV	MINERAL
NV	NYE
NV	STOREY
NV	WASHOE
OK	ALFALFA
OK	BLAINE
OK	BRYAN
OK	CADDO
OK	CANADIAN
OK	CHEROKEE
OK	CLEVELAND
OK	COMANCHE
OK	COTTON
OK	CRAIG
OK	CREEK
OK	DEWEY
OK	GARFIELD
OK	GARVIN
OK	GRADY
OK	GRANT
OK	GREER
OK	HARMON
OK	HUGHES
OK	JACKSON
OK	JEFFERSON
OK	KAY

State	County
OK	KINGFISHER
OK	KIOWA
OK	LINCOLN
OK	LOGAN
OK	MAJOR
OK	MARSHALL
OK	MAYES
OK	MCCLAIN
OK	MCINTOSH
OK	MUSKOGEE
OK	NOBLE
OK	NOWATA
OK	OKFUSKEE
OK	OKLAHOMA
OK	OKMULGEE
OK	OSAGE
OK	PAWNEE
OK	PAYNE
OK	PITTSBURG
OK	POTTAWATOMIE
OK	ROGERS
OK	SEMINOLE
OK	STEPHENS
OK	TILLMAN
OK	TULSA
OK	WAGONER
OK	WOODS
OR	BENTON
OR	CLACKAMAS
OR	COLUMBIA
OR	COOS
OR	CURRY
OR	DESHUTES
OR	DOUGLAS
OR	JACKSON
OR	JOSEPHINE
OR	LANE
OR	LINCOLN
OR	LINN
OR	MARION
OR	MULTNOMAH
OR	POLK

State	County
OR	WASHINGTON
OR	YAMHILL
SC	AIKEN
SC	ANDERSON
SC	BEAUFORT
SC	BERKELEY
SC	CALHOUN
SC	CHARLESTON
SC	CHEROKEE
SC	CHESTERFIELD
SC	DILLON
SC	DORCHESTER
SC	FAIRFIELD
SC	FLORENCE
SC	GEORGETOWN
SC	GREENVILLE
SC	HORRY
SC	KERSHAW
SC	LEXINGTON
SC	MARION
SC	MARLBORO
SC	NEWBERRY
SC	OCONEE
SC	ORANGEBURG
SC	PICKENS
SC	RICHLAND
SC	SALUDA
SC	SPARTANBURG
SC	SUMTER
SC	YORK
SD	AURORA
SD	BON HOMME
SD	BROOKINGS
SD	BUTTE
SD	CAMPBELL
SD	CHARLES MIX
SD	CLARK
SD	CLAY
SD	CORSON
SD	CUSTER
SD	DAVISON
SD	DAY

State	County
SD	DEUEL
SD	DEWEY
SD	DOUGLAS
SD	EDMUNDS
SD	FALL RIVER
SD	HAAKON
SD	HARDING
SD	HANSON
SD	HUTCHINSON
SD	JACKSON
SD	JERAULD
SD	KINGSBURY
SD	LAKE
SD	LAWRENCE
SD	LINCOLN
SD	MARSHALL
SD	MCCOOK
SD	MCPHERSON
SD	MEADE
SD	MINER
SD	MINNEHAHA
SD	MOODY
SD	PENNINGTON
SD	PERKINS
SD	ROBERTS
SD	SANBORN
SD	TURNER
SD	UNION
SD	WALWORTH
SD	YANKTON
SD	ZIEBACH
TX	ANDERSON
TX	ARANSAS
TX	ARCHER
TX	ATASCOSA
TX	AUSTIN
TX	BANDERA
TX	BASTROP
TX	BEE
TX	BELL
TX	BEXAR
TX	BLANCO

State	County
TX	BOSQUE
TX	BOWIE
TX	BRAZORIA
TX	BRAZOS
TX	BROOKS
TX	BURLESON
TX	BURNET
TX	CALDWELL
TX	CALHOUN
TX	CAMERON
TX	CAMP
TX	CASS
TX	CHAMBERS
TX	CHEROKEE
TX	CLAY
TX	COLLIN
TX	COLORADO
TX	COMAL
TX	COOKE
TX	CORYELL
TX	DALLAS
TX	DELTA
TX	DENTON
TX	DEWITT
TX	DIMMIT
TX	DUVAL
TX	EL PASO
TX	ELLIS
TX	ERATH
TX	FALLS
TX	FANNIN
TX	FAYETTE
TX	FORT BEND
TX	FRANKLIN
TX	FREESTONE
TX	GALVESTON
TX	GOLIAD
TX	GONZALES
TX	GRAYSON
TX	GREGG
TX	GRIMES
TX	GUADALUPE

State	County
TX	HAMILTON
TX	HARDIN
TX	HARRIS
TX	HARRISON
TX	HAYS
TX	HENDERSON
TX	HIDALGO
TX	HILL
TX	HOOD
TX	HOPKINS
TX	HOUSTON
TX	HUDSPETH
TX	HUNT
TX	JACK
TX	JACKSON
TX	JEFFERSON
TX	JIM HOGG
TX	JIM WELLS
TX	JOHNSON
TX	KARNES
TX	KAUFMAN
TX	KENDALL
TX	KENEDY
TX	KLEBERG
TX	LA SALLE
TX	LAMAR
TX	LAMPASAS
TX	LAVACA
TX	LEE
TX	LEON
TX	LIBERTY
TX	LIMESTONE
TX	LLANO
TX	MADISON
TX	MASON
TX	MATAGORDA
TX	MAVERICK
TX	MCCULLOCH
TX	MCLENNAN
TX	MCMULLEN
TX	MEDINA
TX	MILAM

State	County
TX	MILLS
TX	MONTGOMERY
TX	MORRIS
TX	NACOGDOCHES
TX	NAVARRO
TX	NUECES
TX	ORANGE
TX	PALO PINTO
TX	PANOLA
TX	PARKER
TX	POLK
TX	POTTER
TX	RAINS
TX	RANDALL
TX	REAL
TX	REFUGIO
TX	ROBERTSON
TX	ROCKWALL
TX	RUSK
TX	SAN JACINTO
TX	SAN PATRICIO
TX	SAN SABA
TX	SHACKELFORD
TX	SHELBY
TX	SMITH
TX	SOMERVELL
TX	STARR
TX	TARRANT
TX	THROCKMORTON
TX	TITUS
TX	TOMGREEN
TX	TRAVIS
TX	TRINITY
TX	TYLER
TX	UPSHUR
TX	UVALDE
TX	VAN ZANDT
TX	VICTORIA
TX	WALKER
TX	WALLER
TX	WASHINGTON
TX	WEBB

State	County
TX	WHARTON
TX	WILLACY
TX	WILLIAMSON
TX	WILSON
TX	WISE
TX	WOOD
TX	YOUNG
TX	ZAVALA
UT	BOX ELDER
UT	CACHE
UT	DAVIS
UT	IRON
UT	MORGAN
UT	SALT LAKE
UT	SUMMIT
UT	TOOELE
UT	UTAH
UT	WASATCH
UT	WASHINGTON
UT	WEBER
WA	ASOTIN

State	County
WA	CLARK
WA	COLUMBIA
WA	COWLITZ
WA	GRAYS HARBOR
WA	ISLAND
WA	JEFFERSON
WA	KING
WA	KITSAP
WA	LEWIS
WA	MASON
WA	PIERCE
WA	SKAGIT
WA	SNOHOMISH
WA	THURSTON
WA	WAHKIAKUM
WA	WALLA WALLA
WA	WHATCOM
WA	YAKIMA
WY	ALBANY
WY	BIG HORN
WY	CAMPBELL

State	County
WY	CARBON
WY	CONVERSE
WY	CROOK
WY	FREMONT
WY	GOSHEN
WY	HOT SPRINGS
WY	JOHNSON
WY	LARAMIE
WY	LINCOLN
WY	NATRONA
WY	NIOBRARA
WY	PARK
WY	PLATTE
WY	SUBLETTE
WY	SWEETWATER
WY	TETON
WY	UINTA
WY	WASHAKIE
WY	WESTON

Agency Contact Information by State

If no TTY number is listed for an agency, you may call the national TTY relay number 711 for assistance.

	SHIP	QIO	MEDICAID	SPAP	ADAP
Alabama	1-800-243-5463	888-317-0751 TTY: 855-843-4776	1-800-362-1504	NA	1-866-574-9964
Alaska	1-800-478-6065 TTY: 1-800-770-8973	888-305-6759 TTY: 855-843-4776	1-800-780-9972	NA	1-800-478-2437
Arizona	1-800-432-4040	877-588-1123 TTY:855-887-6668	1-800-523-0231	NA	1-602-364-3610
Arkansas	1-800-224-6330	888-315-0636 TTY: 855-843-4776	1-800-482-8988	NA	1-501-661-2408
California	1-800-434-0222	877-588-1123 TTY:855-887-6668	1-916-636-1980	NA	1-916-558-1784
Colorado	1-888-696-7213	888-317-0891 TTY: 855-843-4776	1-800-221-3943	1-303-692-2716	1-303-692-2716
Connecticut	1-800-994-9422	888-319-8452 TTY: 855-843-4776	1-800-842-1508	1-800-423-5026	1-800-233-2503
Delaware	1-800-336-9500	888-396-4646 TTY: 888-985-2660	1-800-372-2022	1-800-996-9969	1-302-744-1050
District of Columbia	1-202-727-8370	888-396-4646 TTY: 888-985-2660	1-202-724-5626	NA	1-202-671-4900
Florida	1-800-963-5337	888-317-0751 TTY: 855-843-4776	1-866-762-2237	NA	1-850-245-4422
Georgia	1-866-552-4464	888-317-0751 TTY: 855-843-4776	1-877-423-4746	NA	1-404-656-9805
Guam	1-671-735-7415	877-588-1123 TTY:855-887-6668	1-671-735-7231	NA	1-671-735-3603
Hawaii	1-888-875-9229	877-588-1123 TTY:855-887-6668	1-877-628-5076	NA	1-808-733-9360
Idaho	1-800-247-4422	888-305-6759 TTY: 855-843-4776	1-877-456-1233	1-208-334-5943	1-208-334-5612
Illinois	1-800-252-8966	888-524-9900 TTY: 888-985-8775	1-800-226-0768	1-800-226-0768	1-800-825-3518
Indiana	1-800-452-4800	888-524-9900 TTY: 888-985-8775	1-800-403-0864	1-866-267-4679	1-866-588-4948
Iowa	1-800-351-4664 TTY: 1-800-735-2942	888-755-5580 TTY: 888-985-9295	1800-338-8366	NA	1-800-972-2017 TTY: 1-800-735-2942.
Kansas	1-800-860-5260	888-755-5580	1-800-792-4884	NA	1-785-296-6174

	SHIP	QIO	MEDICAID	SPAP	ADAP
		TTY: 888-985-9295			
Kentucky	1-877-293-7447	888-317-0751 TTY: 855-843-4776	1-800-635-2570	NA	1-866-510-0005
Louisiana	1-800-259-5300	888-315-0636 TTY: 855-843-4776	1-888-342-6207	NA	1-504-568-7474
Maine	1-877-353-3771	888-319-8452 TTY: 855-843-4776	1-207-287-3707	NA	1-207-287-3747
Massachusetts	1-800-243-4636	888-319-8452 TTY: 855-843-4776	1-800-841-2900	NA	1-617-502-1700
Michigan	1-800-803-7174	888-524-9900 TTY: 888-985-8775	1-517-373-3740	NA	1-888-826-6565
Minnesota	1-800-333-2433 TTY: 1-800-627-3529	888-524-9900 TTY: 888-985-8775	1-800-366-5411	NA	1-651-431-2414
Mississippi	1-844-822-4622	888-317-0751 TTY: 855-843-4776	1-800-421-2408	NA	1-888-343-7373
Missouri	1-800-390-3330	888-755-5580 TTY: 888-985-9295	1-800-392-2161	1-800-375-1406	1-573-751-6439
Montana	1-800-551-3191	888-317-0891 TTY: 855-843-4776	1-800-362-8312	1-866-369-1233	1-406-444-3565
Nebraska	1-800-234-7119	888-755-5580 TTY: 888-985-9295	1-855-632-7633	NA	1-402-471-2101
Nevada	1-800-307-4444	877-588-1123 TTY:855-887-6668	1-877-638-3472	1-866-303-6323	1-702-274-2453
New Hampshire	1-866-634-9412	888-319-8452 TTY: 855-843-4776	1-844-275-3447	NA	1-800-852-3345
New Jersey	1-800-792-8820	866-815-5440 TTY: 866-868-2289	1-800-701-0710	1-800-792-9745	1-877-613-4533
New Mexico	1-800-432-2080 TTY: 1-505-476-4937	888-315-0636 TTY: 855-843-4776	1-888-997-2583	NA	1-505-476-3628
New York	1-800-701-0501	866-815-5440 TTY: 866-868-2289	1-800-541-2831	1-800-332-3742	1-800-542-2437
North Carolina	1-855-408-1212	888-317-0751 TTY: 855-843-4776	1-800-662-7030	1-888-311-7632	1-877-466-2232
North Dakota	1-888-575-6611 TTY: 1-800-366-6888	888-317-0891 TTY: 855-843-4776	1-800-755-2604	NA	1-800-472-2180
Ohio	1-800-686-1578 TTY: 1-614-644-3745	888-524-9900 TTY: 888-985-8775	1-800-324-8680	NA	1-800-777-4775
Oklahoma	1-800-763-2828	888-315-0636	1-800-522-0310	NA	1-405-271-4636

	SHIP	QIO	MEDICAID	SPAP	ADAP
		TTY: 855-843-4776			
Oregon	1-800-722-4134	888-305-6759 TTY: 855-843-4776	1-800-527-5772	971-673-0144	971-673-0144
Pennsylvania	1-800-783-7067	888-396-4646 TTY: 888-985-2660	1-866-550-4355	1-800-225-7223	1-800-922-9384
Puerto Rico	1-877-725-4300 TTY: 1-787-919-7291	866-815-5440 TTY: 866-868-2289	1-787-641-4224	NA	1-787-765-2929 ext.5107
Rhode Island	1-888-884-8721 TTY: 1-401-462-0740	888-319-8452 TTY: 855-843-4776	1-855-840-4774	1-401-462-3000	1-401-462-3295
South Carolina	1-800-868-9095	888-317-0751 TTY: 855-843-4776	1-888-549-0820	1-888-549-0820	1-800-856-9954
Tennessee	1-877-801-0044	888-317-0751 TTY: 855-843-4776	1-855-259-0701	NA	1-800-525-2437
Texas	1-800-252-9240 TTY: 1-800-735-2989	888-315-0636 TTY: 855-843-4776	1-800-335-8957	1-800-222-3986	1-800-255-1090
Utah	1-800-541-7735	888-317-0891 TTY: 855-843-4776	1-800-662-9651	NA	1-801-538-6191
Vermont	1-800-642-5119	888-319-8452 TTY: 855-843-4776	1-800-250-8427	1-800-250-8427	1-802-951-4005
U.S. Virgin Islands	1-340-772-7368	866-815-5440 TTY: 866-868-2289	St. Thomas: 1-340-774-0930 St. Croix: 1-340-718-2980 St. John: 1-340-776-6334	1-340-774-0930	1-340-774-9000 ext.4700
Virginia	1-800-552-3402	888-396-4646 TTY: 888-985-2660	1-804-786-7933	1-800-552-3402	1-855-362-0658
Washington	1-800-562-6900 TTY: 1-360-586-0241	888-305-6759 TTY: 855-843-4776	1-800-562-3022	1-800-877-5187	1-800-877-5187
West Virginia	1-877-987-4463	888-396-4646 TTY: 888-985-2660	1-800-642-8589	NA	1-304-232-6822
Wisconsin	1-800-242-1060	888-524-9900 TTY: 888-985-8775	1-800-362-3002	1-800-657-2038	1-800-991-5532
Wyoming	1-800-856-4398	888-317-0891 TTY: 855-843-4776	1-866-571-0944	NA	1-307-777-7529

Highmark Blue Shield is a Medicare Advantage HMO, PPO, and/or Part D plan with a Medicare contract. Enrollment in these plans depends on contract renewal.

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Highmark Senior Health Company is an independent licensee of the Blue Cross Blue Shield Association. This agreement is between the subscriber and Highmark Senior Health Company ("Licensee") only. Licensee is an independent corporation operating under a license from the Blue Cross Blue Shield Association ("the Association"), which is a national association of independent Blue Cross and Blue Shield plans throughout the United States. Although all of these independent Blue Cross and/or Blue Shield plans operate from a license with the Association, each of them is a separate and distinct corporation. The Association allows Licensee to use the familiar Blue words and symbols in certain portions of Pennsylvania. Licensee, upon entering into this agreement, is not contracting as an agent of the national Association. The subscriber agrees that it has not entered into this agreement based upon representations made by any person or entity other than Licensee. Only Licensee shall be liable to the subscriber for any of Licensee's obligations under this agreement. This paragraph does not add any obligations to this agreement.

Express Scripts, Evernorth's pharmacy benefit services business, is an independent company that manages your prescription benefits for your health plan. Other Pharmacies are available in our network.

Freedom Blue PPO Member Services

Method	Contact Information
CALL	1-800-550-8722 **(Your employer group may have a dedicated phone number, please refer to the number on the back of your ID card for the most accurate phone number.)** Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 National Relay Service This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Monday through Sunday, 8:00 a.m. to 8:00 p.m., Eastern Time.
FAX	1-717-635-4235
WRITE	P.O. Box 1068 Pittsburgh, PA 15230-1068
WEBSITE	medicare.highmark.com

State Health Insurance Assistance Program

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Your state-specific SHIP can be found in the *Agency Contact Information* appendix in this document.