



January 1 – December 31, 2024

Evidence of Coverage:

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

This document gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2024. **This is an important legal document. Please keep it in a safe place.**

For questions about this document, please contact Member Service 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 information is available in alternate formats such as large print.

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2025.

The formulary, pharmacy and/or provider network may change at any time. You will receive notice when necessary. We will notify affected enrollees about changes at least 30 days in advance.

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

- Your plan premium and cost sharing;
- Your medical and prescription drug benefits;
- How to file a complaint if you are not satisfied with a service or treatment;
- How to contact us if you need further assistance; and,
- Other protections required by Medicare law.

OMB Approval 0938-1051 (Expires: February 29, 2024)



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CHAPTER 1:

Getting started as a member

CHAPTER 1. Getting started as a member**SECTION 1 Introduction****Section 1.1 You are enrolled in Freedom Blue PPO, which is a Medicare PPO**

You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Freedom Blue PPO. We are required to cover all Part A and Part B services. However, cost sharing and provider access in this plan differ 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.

Coverage under this Plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: www.irs.gov/affordable-care-act/individuals-and-families for more information.

Section 1.2 What is the *Evidence of Coverage* document about?

This *Evidence of Coverage* document tells you how to get your medical care and prescription drugs. It explains your rights and responsibilities, what is covered, what you pay as a member of the plan, and how to file a complaint if you are not satisfied with a decision or treatment.

The words *coverage* and *covered services* refer to the medical care and services and the prescription drugs available to you as a member of Freedom Blue PPO.

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* document.

If you are confused, concerned, or just have a question, please contact Member Service.

Section 1.3 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 (if applicable), the *List of Covered Drugs (Formulary)*, and any notices you receive 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 months in which you are enrolled in Freedom Blue PPO between January 1, 2024 and December 31, 2024.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Freedom Blue PPO after December 31, 2024. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2024.

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

SECTION 2 What makes you eligible to be a plan member?

Section 2.1 Your eligibility requirements

You are eligible for membership in our plan as long as:

- You have both Medicare Part A and Medicare Part B
- -- *and* -- you live in our geographic service area (Section 2.2 below describes our service area). Incarcerated individuals are not considered living in the geographic service area even if they are physically located in it.
- -- *and* -- you are a United States citizen or are lawfully present in the United States.

Section 2.2 Here is the 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 remain 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 plan to move out of the service area (the United States or its territories), you cannot remain a member of this plan. Please contact Member Service. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.3 U.S. citizen or lawful presence





A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Freedom Blue PPO if you are not eligible to remain a member on this basis. Freedom Blue PPO must disenroll you if you do not meet this requirement.


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SECTION 3 Important membership materials you will receive

Section 3.1 Your plan membership card

While you are a member of our plan, you must use your membership card whenever you get services covered by this plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

  Medicare PPO													
MEMBER NAME FIRSTNAME M LASTNAME MEMBER ID SDRXXXXXXXXXXXX PLAN (80840) 915101460	PCP INFORMATION PCP NAME YXXXXXX												
Group XXXXXXX BC/BS Plan 3XX RxBIN 61001 RxPCN MEDD, RIME RxGrp 1 Formulary Name	Hear/Vision/Dental <table border="1"> <thead> <tr> <th></th> <th>In</th> <th>Out</th> </tr> </thead> <tbody> <tr> <td>Office Visit</td> <td>\$XX</td> <td>\$XX</td> </tr> <tr> <td>Specialist Visit</td> <td>\$XX</td> <td>\$XX</td> </tr> <tr> <td>Emergency Room</td> <td>\$XX</td> <td>\$XX</td> </tr> </tbody> </table> CMS HXXX6 0XX		In	Out	Office Visit	\$XX	\$XX	Specialist Visit	\$XX	\$XX	Emergency Room	\$XX	\$XX
	In	Out											
Office Visit	\$XX	\$XX											
Specialist Visit	\$XX	\$XX											
Emergency Room	\$XX	\$XX											
 													

	www.highmarkblueshield.com/medicare Member Service 1-800-XXX-XXXX Blues on Call 1-888-258-3428 TTY/TDD Service Dial 711 Call before receiving out-of-network care Pre-Confirmation 1-800-452-8507 Medical Abuse 1-800-452-8507 Insurance Abuse 1-800-452-8507
Blues on Call: 24-hour access to nurses who provide health education and support services. To Receive High Level Benefits: Receive care from a network provider. Receiving non-emergency care from an out-of-network provider will result in a reduced level of benefits. Medicare limiting charges apply. Highmark Blue Shield and Company Name> are Independent Licensees of the Blue Cross and Blue Shield Association.	All medical claims should be submitted to the local BC/BS plan.
Express Scripts ATTN: Medicare Part D P.O. Box 14718 Lexington, KY 40512-4718	Pharmacy benefit administrator

Do NOT use your red, white, and blue Medicare card for covered medical services while you are 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 your plan membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card.

Section 3.2 The *Provider/Pharmacy Directory*

The *Provider/Pharmacy Directory* 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 all of the pharmacies that have agreed to fill covered prescriptions for our plan members. You can use the *Provider/Pharmacy Directory* to find the network pharmacy you want to use. See Chapter 5, Section 2.5 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.

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As a member of our plan, you can choose to receive 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. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

If you don't have your copy of the *Provider/Pharmacy Directory*, you can request a copy (electronically or in hardcopy form) from Member Services. Requests for hard copy Provider/Pharmacy Directories will be mailed to you within three business days. You can also find this information on our website at [medicare.highmark.com](https://www.medicare.highmark.com).

Section 3.3 The plan's List of Covered Drugs (*Formulary*)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered under the Part D benefit included in Freedom Blue PPO. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Freedom Blue PPO "Drug List."

The "Drug List" also tells you if there are any rules that restrict coverage for your drugs.

We will provide you a copy of the "Drug List." To get the most complete and current information about which drugs are covered, you can visit the plan's website ([medicare.highmark.com](https://www.medicare.highmark.com)) or call Member Service.

SECTION 4 Your monthly costs for Freedom Blue PPO

Your costs may include the following:

- Plan Premium (Section 4.1)
- Monthly Medicare Part B Premium (Section 4.2)
- Part D Late Enrollment Penalty (Section 4.3)
- Income Related Monthly Adjusted Amount (Section 4.4)

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.

If you are *already enrolled* and getting 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, please call Member Service and ask for the LIS Rider.

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Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums review your copy of *Medicare & You 2024* handbook, the section called *2024 Medicare Costs*. If you need a copy, you can download it from the Medicare website (www.medicare.gov). Or you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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.

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 remain a member of the plan.** This includes your premium for Part B. It may also include a premium for Part A which affects members who 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 (if applicable) that must be paid for Part D coverage if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not 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 prescription 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 will 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 or quarterly 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 **will not** have to pay it if:

- You receive "Extra Help" from Medicare to pay for your prescription drugs.

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- You have gone less than 63 days in a row without creditable coverage.
- You have had creditable drug coverage through another source such as a former employer, union, TRICARE, or Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the 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 prescription drug plan pays.
 - **Note:** The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.

Medicare determines the amount of the penalty. Here is 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, the plan will count the number of full months that you did not have coverage. The penalty is 1% for every month that you did not have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2024, this average premium amount is \$34.70.
- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here, it would be 14% times \$34.70, which equals \$4.858. This rounds to \$4.86. This amount would be added **to the monthly premium for someone with a Part D late enrollment penalty.**

There are three important things to note about this monthly Part D late enrollment penalty:

- First, **the penalty may change each year** because the average monthly premium can change each year.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- Third, if you are under 65 and currently receiving Medicare benefits, 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 that 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 request this review **within 60 days** from the date on the first letter you receive stating you have to pay a late enrollment penalty. However, if you were paying a penalty before joining our plan, you may not have another chance to request a review of that late enrollment penalty.

Important: Do not 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 your plan premiums.

CHAPTER 1. Getting started as a member**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, also known as IRMAA. The extra charge is figured out 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 <https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/monthly-premium-for-drug-plans>.

If you have to pay an extra amount, 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 your 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 will get a bill from Medicare. **You must pay the extra amount to the government. It cannot be paid with your monthly plan premium. If you do not pay the extra amount, you will be disenrolled from the plan and lose prescription drug coverage.**

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

SECTION 5 More information about your monthly premium**Section 5.1 There are several ways you can pay your plan premium and/or Part D late enrollment penalty (if applicable)**

This section applies only to those members who pay their 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. Other billing frequencies, such as quarterly or semi-annually, are available.

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.

P.O. Box 382054

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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 Service 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](https://www.medicare.highmark.com), if your former employer does **not** contribute to the premium. Switching to online e-Bill payment allows you to have your 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 the option by which you pay your plan premium or Part D late enrollment penalty, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium or Part D late enrollment penalty is paid on time. To change your payment method, please contact Member Service.

What to do if you are having 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 have not received your payment by the last day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within three months. If you are required to pay a Part D late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

If you are having trouble paying your premium or Part D late enrollment penalty, if owed, please contact Member Service to see if we can direct you to programs that will help with your costs.

If we end your membership because you did not pay your premium or Part D late enrollment penalty, if owed, you will have health coverage under Original Medicare. In addition, you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual 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 the penalty you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you can make a complaint (also called a grievance); see Chapter 9 for how to file a complaint. If you had an emergency circumstance that

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was out of your control and it caused you to not be able 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 will review our decision again. Chapter 9, Section 10 of this document tells how to make a complaint, or you can 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 request no later than 60 days after the date your membership ends.

Section 5.2 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year, we will tell you in September 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. 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 (if applicable), including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider.

The doctors, hospitals, pharmacists, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered and the cost sharing amounts for you.** Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse or domestic partner's employer, Workers' Compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive 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 are participating in a clinical research study. (**Note:** You are not required to tell your plan about the clinical research studies you intend to participate in but we encourage you to do so)

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If any of this information changes, please let us know by calling Member Service.

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

Other insurance

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. This is called **Coordination of Benefits**.

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Service. You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

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

CHAPTER 1. Getting started as a member

- 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:

Important phone numbers and resources

CHAPTER 2. Important phone numbers and resources**SECTION 1 Freedom Blue PPO contacts**
(how to contact us, including how to reach Member Service)**How to contact our plan's Member Service**

For assistance with claims, billing, or member card questions, please call or write to Freedom Blue PPO Member Service. We will be happy to help you.

Method	Member Service – 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. Member Service 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

How to contact us when you are asking 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 will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on asking for coverage decisions or appeals about your medical care or Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Method	Coverage Decisions for Medical Care or Part D prescription drugs – Contact Information
CALL	1-800-452-8507, option 2 Calls to this number are free. Monday through Friday, 8:30 a.m. to 7:00 p.m., Saturday and Sunday, 8:30 a.m. to 4:30 p.m., Eastern Time. To file an expedited medical organization determination, call 1-800-485-9610, option 2.

CHAPTER 2. Important phone numbers and resources

Method	Coverage Decisions for Medical Care or Part D prescription drugs – Contact Information
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 Friday, 8:30 a.m. to 7:00 p.m., Saturday and Sunday, 8:30 a.m. to 4:30 p.m., Eastern Time.
FAX	1-800-894-7947
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

Method	Appeals for Medical Care or Part D prescription drugs – 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. 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.
FAX	1-717-635-4209 To file an expedited appeal, fax your request to 1-800-894-7947.
WRITE	Appeals and Grievance Dept. P.O. Box 535047 Pittsburgh, PA 15253-5047
WEBSITE	medicare.highmark.com

CHAPTER 2. Important phone numbers and resources**How to contact us when you are making 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)*).

Method	Complaints About Medical Care – 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.
FAX	1-717-635-4209
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 .

Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received

If you have received a bill or paid for services (such as a provider bill) that you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Method	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

CHAPTER 2. Important phone numbers and resources

Method	Payment Requests – Contact Information
	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

SECTION 2 Medicare

(how to get help and information directly from the Federal Medicare program)

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 (sometimes called CMS). This agency contracts with Medicare Advantage organizations including us.

Method	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 with hearing or speaking. Calls to this number are free.
WEBSITE	www.Medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

CHAPTER 2. Important phone numbers and resources

Method	Medicare – Contact Information
	<p>The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:</p> <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. <p>You can also use the website to tell Medicare about any complaints you have about Freedom Blue PPO:</p> <ul style="list-style-type: none"> • 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/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. 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) state program 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, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIP counselors can also help you with Medicare questions or problems and help you understand your Medicare plan choices and answer questions about switching plans.

CHAPTER 2. Important phone numbers and resources

METHOD TO ACCESS SHIP and OTHER RESOURCES:

- Visit <https://www.shiphelp.org> (Click on SHIP LOCATOR in middle of page)
- Select your STATE from the list. This will take you to a page with phone numbers and resources specific to your state.

SECTION 4 Quality Improvement Organization

There is a designated Quality Improvement Organization for serving Medicare beneficiaries 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 who are paid by Medicare to check on and help improve the quality of care for people with Medicare. QIO is an independent organization. It is not connected with our plan.

You should contact QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- 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 are ending too soon.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their 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 a reconsideration.

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

Method	Social Security– Contact Information
CALL	1-800-772-1213

CHAPTER 2. Important phone numbers and resources

Method	Social Security– Contact Information
	<p>Calls to this number are free.</p> <p>Available 8:00 a.m. to 7:00 p.m., Monday through Friday.</p> <p>You can use Social Security’s automated telephone services to get recorded information and conduct some business 24 hours a day.</p>
TTY	<p>1-800-325-0778</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p> <p>Available 8:00 a.m. to 7:00 p.m., Monday through Friday.</p>
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. The programs offered through Medicaid 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 its 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 Information about programs to help people pay for their prescription drugs

The Medicare.gov website (<https://www.medicare.gov/drug-coverage-part-d/costs-for-medicare-drug-coverage/costs-in-the-coverage-gap/5-ways-to-get-help-with-prescription-costs>) provides information on how to lower your prescription drug costs. For people with limited incomes, there are also other programs to assist, described below.

CHAPTER 2. Important phone numbers and resources

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, yearly deductible, and prescription copayments. This "Extra Help" also counts toward your out-of-pocket costs.

If you automatically qualify for "Extra Help" Medicare will mail you a letter. You will not have to apply. If you do not automatically qualify you may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 8 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778 (applications); or
- Your State Medicaid Office (applications). (See Section 6 of this chapter for contact information.)

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost sharing amount when you get your prescription at a pharmacy, our plan has a process for you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Please call Member Service 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 receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make the payment directly to the state. Please contact Member Service if you have questions.

What if you have 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 and the U.S. Virgin Islands offer help paying for prescriptions, drug plan premiums and/or other drug costs. If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 70% discount on covered brand name drugs. Also, the plan pays 5% of the costs of brand drugs in the coverage gap. The 70% discount and the 5% paid by the plan are both applied to the price of the drug before any SPAP or other coverage.

CHAPTER 2. Important phone numbers and resources

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?**What is the AIDS Drug Assistance Program (ADAP)?**

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also on the ADAP formulary qualify for prescription cost sharing assistance 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 operating in your State, individuals 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, please notify your local ADAP enrollment worker so you can continue to receive assistance. For information on eligibility criteria, covered drugs, or how to enroll in the program, please call ADAP program on the *Agency Contact Information* appendix.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some 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.

SECTION 8 How to contact the Railroad Retirement Board

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 receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

CHAPTER 2. Important phone numbers and resources

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>If you press “0,” you may speak with an RRB representative from 9:00 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9:00 a.m. to 12:00 p.m. on Wednesday.</p> <p>If you press “1”, you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
WEBSITE	rrb.gov/

SECTION 9 Do 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, you may call the employer/union benefits administrator or Member Services if you have 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 may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

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

CHAPTER 3:

*Using the plan for your medical
services*

CHAPTER 3. Using the plan for your medical services**SECTION 1 Things to know about getting your medical care as a member of our plan**

This chapter explains what you need to know about using the plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, equipment, prescription drugs, and other medical care that are covered by the plan.

For the details on what medical care is covered by our plan and how much you pay when you get this care, see the *Medical Benefits Chart* appendix.

Section 1.1 What are 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 have 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 getting your medical care covered by the plan

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

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

- **The care you receive is included in the plan's *Medical Benefits Chart* appendix.**
- **The care you receive 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 receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).
 - The providers in our network are listed in the *Provider/Pharmacy Directory*.
 - If you use an out-of-network provider, your share of the costs for your covered services may be higher.

CHAPTER 3. Using the plan for your medical services

Please 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 cannot pay a provider who is not eligible to participate in Medicare. If you go to 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 Using network and out-of-network providers to get your medical care

Section 2.1	You may choose a Primary Care Provider (PCP) to provide and oversee your medical care
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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 much like the “old-fashioned family doctor” – 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 do you 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](https://www.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](https://www.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 Service at the numbers printed on the back cover of this booklet.

CHAPTER 3. Using the plan for your medical services

Changing your PCP

You may change your PCP for any reason at any time. Also, it's possible that your PCP might leave our plan's network of providers and you would have to find a new PCP in our plan or you will pay more for covered services.

To change your PCP, contact Member Service. They will check to be sure the PCP you want is accepting new patients. Member Service 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
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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. Here are a few examples:

- 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 Service 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.

CHAPTER 3. Using the plan for your medical services

What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. If your doctor or specialist leaves your plan you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will notify you that your provider is leaving our plan so that you have time to select a new provider.
 - If your primary care or behavioral health provider leaves our plan, we will notify you if you have seen that provider within the past three years.
 - If any of your other providers leave our plan, we will notify you if you are assigned to the provider, currently receive care from them, or have seen them within the past three months.
- We will assist you in selecting a new qualified in-network provider that you may access for continued care.
- If you are undergoing medical treatment or therapies with your current provider, you have the right to request, and we will work with you to ensure, that the medically necessary treatment or therapies you are receiving continues.
- We will provide you with information about the different enrollment periods available to you and options you may have for changing plans.
- We will arrange for any medically necessary covered benefit outside of our provider network, but at in-network cost sharing, when an in-network provider or benefit is unavailable or inadequate to meet your medical needs.
- If you find out your doctor or specialist is leaving your plan, please contact us so we can assist you in finding a new provider to manage your care.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file a quality of care complaint to the QIO, a quality of care grievance to the plan, or both. Please see Chapter 9.

Section 2.3 Blue Cross Blue Shield Association Network Sharing
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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, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland,

CHAPTER 3. Using the plan for your medical services

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, and West Virginia. 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 Service (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](https://www.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

CHAPTER 3. Using the plan for your medical services

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
<i>With a participating Medicare Advantage PPO network</i>	Full coverage after you pay a small copayment or coinsurance	80%* coverage after you pay an annual deductible
<i>Without a participating Medicare Advantage PPO network</i>	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 Service 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
<i>With a participating Medicare Advantage PPO network</i>	Full coverage after you pay a small copayment or coinsurance	80%* coverage after you pay an annual deductible
<i>Without a participating Medicare Advantage PPO network</i>	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 Service 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.

CHAPTER 3. Using the plan for your medical services

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 receive care from out-of-network providers. However, please note providers that do not 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 are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.**

Here are other 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 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.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 9, Section 4 for information about asking for coverage decisions.) This is important because:
 - Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 9 (*What to do if you have a problem or complaint*) to learn how to make an appeal.
- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are 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. See Section 3 for more information about these situations.

CHAPTER 3. Using the plan for your medical services**SECTION 3 How to get services when you have an emergency or urgent need for care or during a disaster****Section 3.1 Getting care if you have a medical emergency****What is a medical emergency and what should you do if you have one?**

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent your loss of life (and, if you are 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 is 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 do *not* need to get approval or a referral first from your PCP. You do not need to use a network doctor. You may 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 are not part of our network.
- **As soon as possible, make sure that 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 Service at the number included on the back of this book. You can also locate the phone number on the back of your ID card.

What is covered if you have 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 who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are 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 will 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

CHAPTER 3. Using the plan for your medical services

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

However, after the doctor has said that it was *not* 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 Getting care when you have an urgent need for services

What are urgently needed services?

An urgently needed service is a non-emergency situation requiring immediate medical care but given your circumstances, it is not possible or not reasonable to obtain these services from a network provider. The plan must cover urgently needed services provided out of network. Some examples of urgently needed services are i) a severe sore throat that occurs over the weekend or ii) an unforeseen flare-up of a known condition when you are temporarily outside the service area.

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](https://www.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 Getting 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 are still entitled to care from your plan.

Please visit the following website: [medicare.highmark.com](https://www.medicare.highmark.com) for information on how to obtain needed care during a disaster.

If you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

CHAPTER 3. Using the plan for your medical services

SECTION 4 What if you are billed directly for the full cost of your services?

Section 4.1 You can ask us to pay our share of the cost of covered services

If you have paid more than your plan cost sharing for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*) for information about what to do.

Section 4.2 If services are not 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 receive services not covered by our plan, you are 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 have used up your benefit for that type of covered service. These payments will not count toward your out-of-pocket maximum. You can call Member Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are 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 request volunteers to participate in the study.

Once Medicare approves the study, and you express interest, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study *and* you have a full understanding and acceptance of what is involved if you participate in the study.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. If you tell us that you are in a qualified clinical trial, then you are 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 will reimburse the difference between what you paid and the in-network cost sharing. However, you will need to provide documentation to show us how much you paid. When you are in a clinical

CHAPTER 3. Using the plan for your medical services

research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in any Medicare-approved clinical research study, you do *not* need to tell us or to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers. Please note that this does not include benefits for which our plan is responsible that include, as a component, a clinical trial or registry to assess the benefit. These include certain benefits specified under national coverage determinations (NCDs) and investigational device trials (IDE) and may be subject to prior authorization and other plan rules.

Although you do not need to get our plan's permission to be in a clinical research study, covered for Medicare Advantage enrollees by Original Medicare, we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you receive as part of the study, including:

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

After Medicare has paid its share of the cost for these services, our plan will pay the difference between the cost sharing in Original Medicare and your in-network cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan. However, you are required to submit documentation showing how much cost sharing you paid. Please see Chapter 7 for more information for submitting requests for payments.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and you would pay the \$20 copay required under Original Medicare. You would then notify your plan that you received a qualified clinical trial service and submit documentation, such as a provider bill, to the plan. The plan would then directly pay you \$10. Therefore, your net payment is \$10, the same amount you would pay under our plan's benefits. Please note that in order to receive payment from your plan, you must submit documentation to your plan such as a provider bill.

CHAPTER 3. Using the plan for your medical services

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing unless Medicare would cover the item or service even if you were *not* in a study.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by visiting the Medicare website to read or download the publication *Medicare and Clinical Research Studies*. (The publication is available at: www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf.)

You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1 What is 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 will instead provide coverage for 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 Receiving 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 are conscientiously opposed to getting medical treatment that is **non-excepted**.

- **Non-excepted** medical care or treatment is any medical care or treatment that is *voluntary* and *not required* by any federal, state, or local law.
- **Excepted** medical treatment is medical care or treatment that you get that is *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's coverage of services you receive is limited to non-religious aspects of care.

CHAPTER 3. Using the plan for your medical services

- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – and – you must get approval in advance from our plan before you are admitted to the facility or your stay will not 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	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as 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 use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that 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, however, you usually will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan, even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan. Under certain limited circumstances, we will transfer ownership of the DME item to you. Call Member Service for more information.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. The payments made while enrolled in your plan do not count.

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 do not count. You will 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 were in our plan but did not obtain ownership while in our plan. You then go back to Original Medicare. You will have to make 13 consecutive new payments to own the item once you join Original Medicare again. All previous payments (whether to our plan or to Original Medicare) do not count.

CHAPTER 3. Using the plan for your medical services**Section 7.2 Rules for oxygen equipment, supplies, and maintenance****What oxygen benefits are you entitled to?**

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, then the oxygen equipment must be returned.

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

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

CHAPTER 4:

Medical Benefits Chart (what is covered and what you pay)

CHAPTER 4. Medical Benefits Chart (what is 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 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- **Deductible** is the amount you must pay for medical services before our plan begins to pay its share.
- **Copayment** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **Coinsurance** is 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 in Section 2 tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments, or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable.

Section 1.2 What is your 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 have 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.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services, including in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet. The deductible does not apply to the following services:

- Emergency and urgently needed care
- Health education and management programs (may have a separate deductible for OON)
- Medicare covered chiropractic services
- Medicare covered diabetes self-management training and fasting plasma glucose tests
- Medicare covered medical nutrition therapy and kidney disease education services

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

- Medicare covered preventive care, screening tests, and immunizations
- Medicare covered vision and hearing exams
- Psychiatric physician services
- Primary Care Physician (PCP) and Specialist physician office visits
- Routine vision and hearing services, if applicable

Section 1.3 What is the most you will pay for Medicare Part A and Part B covered medical services?

Under our plan, there are two different limits on what you have to 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 received 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 prescription drugs, and services from out-of-network providers do not 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 have paid the maximum for covered Part A and Part B services from network providers, you will not have any out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your 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 received from both in-network and out-of-network providers. 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 your plan premiums and for your Part D prescription drugs do not 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 amount for covered services has been met, you will have 100% coverage and will not 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).

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)**Section 1.4 Our plan may also limit 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 Our plan does not allow providers to balance bill you

As a member of Freedom Blue PPO, an important protection for you is that you only have to pay your cost sharing amount when you get services covered by our plan. Providers may not add 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 is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider. You will generally have higher copays when you obtain care from out-of-network providers.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
 - If you obtain 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 obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers.
- If you believe a provider has balance billed you, call Member Service.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 2 Use the *Medical Benefits Chart* to find out what is covered and how much you will pay

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 Change (ANOC) you receive during the Annual Election Period.

SECTION 3 What services are not covered by the plan?

Section 3.1 Services we do *not* cover (exclusions)

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

The chart below lists services and items that either are not 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 receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

The only exception is if the service is appealed and decided: upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this document.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Acupuncture		<ul style="list-style-type: none"> Available for people with chronic low back pain under certain circumstances. Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> appendix.
Cosmetic surgery or procedures		<ul style="list-style-type: none"> Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		<ul style="list-style-type: none"> • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
<p>Custodial care Custodial care is personal care that does not 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.</p>	<p>Not covered under any condition</p>	
<p>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.</p>		<ul style="list-style-type: none"> • May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. <p>(See Chapter 3, Section 5 for more information on clinical research studies.)</p>
<p>Fees charged for care by your immediate relatives or members of your household.</p>	<p>Not covered under any condition</p>	
<p>Full-time nursing care in your home.</p>	<p>Not covered under any condition</p>	
<p>Home-delivered meals</p>		<p>Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> appendix.</p>
<p>Homemaker services including basic household assistance, such as light housekeeping or light meal preparation.</p>	<p>Not covered under any condition</p>	
<p>Naturopath services (uses natural or alternative treatments).</p>	<p>Not covered under any condition</p>	

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Non-routine dental care		<ul style="list-style-type: none"> Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
Orthopedic shoes or supportive devices for the feet		<ul style="list-style-type: none"> 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	
Private room in a hospital.		<ul style="list-style-type: none"> Covered only when medically necessary.
Reversal of sterilization procedures and or non-prescription contraceptive supplies.	Not covered under any condition	
Routine chiropractic care		<ul style="list-style-type: none"> Manual manipulation of the spine to correct a subluxation is covered. <p>Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> appendix.</p>
Routine dental care, such as cleanings, filling or dentures.		<p>Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> appendix.</p>
Routine eye examinations and eyeglasses		<ul style="list-style-type: none"> 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 <i>Medical Benefits Chart</i> appendix.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care		<ul style="list-style-type: none"> Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes. <p>Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> appendix.</p>
Routine hearing exams, hearing aids, or exams to fit hearing aids.		Your specific group benefit plan may have additional coverage, please see the <i>Medical Benefits Chart</i> 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 <i>Medical Benefits Chart</i> appendix.	Not covered under any condition	
Vision - Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.	Not covered under any condition	

CHAPTER 5:

*Using the plan's coverage for your
Part D prescription drugs*

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

SECTION 1 Introduction

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.

Section 1.1 Basic rules for the plan's Part D drug coverage

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

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription which must be 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. (See Section 2, *Fill your prescriptions at a network pharmacy or through the plan's mail-order service*).
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's "Drug List"*).
- Your drug must be used for a medically accepted indication. A medically accepted indication is a use of the drug that is either approved by the Food and Drug Administration or supported by certain references. (See Section 3 for more information about a medically accepted indication.)

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

Section 2.1 Use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.2 Network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Provider/Pharmacy Directory*, visit our website (medicare.highmark.com), and/or call Member 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 of our network pharmacies provide preferred cost sharing, which may be lower than the cost sharing at a pharmacy that offers standard cost

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

sharing. The *Provider/Pharmacy Directory* will tell you which of the network pharmacies offer preferred cost sharing. Contact us to find out more about how your out-of-pocket costs could vary for different drugs.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. Or if the pharmacy you have been using stays within the network but is no longer offering preferred cost sharing, you may want to switch to a different network or preferred pharmacy, if your employer coverage offers a preferred network option. To find another pharmacy in your area, you can get help from Member Service or use the *Provider/Pharmacy Directory*. You can also find information on our website at [medicare.highmark.com](https://www.medicare.highmark.com).

What if you need a specialized pharmacy?

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 any difficulty accessing your Part D benefits in an LTC facility, please contact Member 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 that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (**Note:** This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Provider/Pharmacy Directory* or call Member Service.

Section 2.3 Using the plan's mail-order services
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Our plan's mail-order service allows you to order **up to a 90-day supply**.

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

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 receives directly from your doctor's office.

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

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

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

- You sign up for automatic delivery of all new prescriptions received directly from health care providers. You may request 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 receive a prescription automatically by mail that you do not want, and you were not contacted to see if you wanted it before it shipped, you may be eligible for a refund.

If you used mail-order in the past and do not want the pharmacy to automatically fill and ship each new prescription, please contact us by calling 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 Service 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 have never used our mail-order delivery and/or decide to stop automatic fills of new prescriptions, the pharmacy will contact you each time it gets a new prescription from a health care provider to see if you want the medication filled and shipped immediately. It is important that you respond each time you are 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, please 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 Service 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, please 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 receive a refill automatically by mail that you do not want, you may be eligible for a refund.

Section 2.4 How can you get a long-term supply of drugs?
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When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two 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 that 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* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Service for more information.
2. You may also receive maintenance drugs through our mail-order program. Please see Section 2.3 for more information.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs**Section 2.5 When can you use a pharmacy that is not in the plan's network?****Your prescription may be covered in certain situations**

Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. To help you, we have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. **Please check first with Member Service** to see if there is a network pharmacy nearby. You will most likely be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost that we would cover at an in-network pharmacy.

Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

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.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

- If you were evacuated or displaced from your residence due to a state or federally declared disaster or health emergency.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will 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. (Chapter 7, Section 2 explains how to ask the plan to pay you back.)

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

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

The plan has a *List of Covered Drugs (Formulary)*. In this *Evidence of Coverage*, we call it the **"Drug List" for short.**

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

The drugs on the "Drug List" are only those covered under Medicare Part D.

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

Approved by the Food and Drug Administration for the diagnosis or condition for which it is being prescribed.

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

The "Drug List" includes brand name drugs, generic drugs, and biosimilars.

A brand name drug is a prescription drug that is sold under a trademarked name owned by the drug manufacturer. Brand name drugs that are more complex than typical drugs (for example, drugs that are based on a protein) are called biological products. 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. Since biological products are more complex than typical drugs, instead of having a generic form, they have alternatives that are called biosimilars. Generally, generics and biosimilars work just as well as the brand name drug or biological product and usually cost less. There are generic drug substitutes or biological alternatives available for many brand name drugs. There are biosimilar alternatives for some biological products.

What is *not* on the "Drug List?"

The plan does not cover all prescription drugs.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).

In other cases, we have decided not to include a particular drug on the "Drug List." In some cases, you may be able to obtain a drug that is not on the drug list. For more information, please see Chapter 9.

Section 3.2 There are five cost sharing tiers for drugs on the "Drug List"

Every drug on the plan's "Drug List" is in one of five cost sharing tiers. In general, the higher the cost sharing 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 the 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 can you find out if a specific drug is on the "Drug List"?

You have four ways to find out:

1. Check the most recent "Drug List" we provided electronically.
2. Visit the plan's website (medicare.highmark.com). The "Drug List" on the website is always the most current.
3. Call Member Service to find out if a particular drug is on the plan's "Drug List" or to ask for a copy of the list.
4. Use the plan's "Real-Time Benefit Tool" (medicare.highmark.com) or by calling Member Services). With this tool you can search for drugs on the "Drug List" to see an estimate of what you will pay and if there are alternative drugs on the "Drug List" that could treat the same condition.

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the 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

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

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

Please 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 instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

The sections below tell you more about the types of restrictions we use for certain drugs.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. Contact Member Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will 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. (See Chapter 9)

Restricting brand name drugs or original biological products when a generic or interchangeable biosimilar version is available

Generally, a **generic** drug or interchangeable biosimilar works the same as a brand name drug or original biological product and usually costs less. **When a generic or interchangeable biosimilar version of a brand name drug or original biological product is available, our network pharmacies will provide you the generic or interchangeable biosimilar version instead of the brand name drug or original biological product.** However, if your provider has told us the medical reason that neither the generic drug or interchangeable biosimilar will not work for you then we will cover the brand name drug or original biological product. (Your share of the cost may be greater for the brand name drug or original biological product than for the generic drug or interchangeable biosimilar.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will 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 do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **step therapy**.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

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 is 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 if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

There are situations where there is a prescription drug you are taking, or one that you and your provider think you should be taking, that is not on our formulary or is on our formulary with restrictions. For example:

- The drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- The drug is covered, but there are extra rules or restrictions on coverage for that drug, as explained in Section 4.
- The drug is covered, but it is in a cost sharing tier that makes your cost sharing more expensive than you think it should be.
- There are things you can do if your drug is not covered in the way that you'd like it to be covered. If your drug is not on the "Drug List" or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2 What can you do if your drug is not on the "Drug List" or if the drug is restricted in some way?

If your drug is not on the "Drug List" or is restricted, here are options:

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

You may be able to get a temporary supply

Under certain circumstances, the plan must provide a temporary supply of a drug that you are already taking. This temporary supply gives you time to talk with your provider about the change in coverage and decide what to do.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

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

- **If you are a new member**, we will cover a temporary supply of your drug during the first 90 days of your membership in the plan.
- **If you were in the plan last year**, we will 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 will allow multiple fills to provide up to a maximum of 31 days of medication. The prescription must be filled at a network pharmacy. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will 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 Service.

During the time when you are 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 two options:

1) You can change to another drug

Talk with your provider about whether there is a different drug covered by the plan that may work just as well for you. You can call Member 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 the plan to make an exception and cover the drug in the way you would like it covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception. For example, you can ask the plan to cover a drug even though it is not on the plan's "Drug List." Or you can ask the plan to make an exception and cover the drug without restrictions.

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will tell you about any change prior to the new year. You can ask for an exception before next year and we will give you an answer within 72 hours after we receive your request (or your prescriber's supporting statement). If we approve your request, we will authorize the coverage before the change takes effect.

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

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs**Section 5.3 What can you 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 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.

You can ask for an exception

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

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

Drugs in our Specialty Tier 5 are not eligible for this type of exception. We do not lower the cost sharing amount for drugs in this tier.

SECTION 6 What if your coverage changes for one of your drugs?**Section 6.1 The "Drug List" can change during the year**

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

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs**Section 6.2 What happens if coverage changes for a drug you are taking?****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" on a regularly scheduled basis. Below we point out the times that you would get direct notice if changes are made to a drug that you are taking.

Changes to your drug coverage that affect you during the current plan year

- **A new generic drug or interchangeable biosimilar replaces a brand name drug on the "Drug List" (or we change the cost sharing tier or add new restrictions to the brand name drug or both)**
 - We may remove a brand name drug or original biological product from our "Drug List" if we are replacing it with a generic version of the same drug or an interchangeable biosimilar version of the same biological product. We may decide to keep the brand name drug or original biological product on our "Drug List" but move it to a higher cost-sharing tier or add new restrictions or both when the generic or interchangeable biosimilar is added.
 - We may not tell you in advance before we make that change—even if you are currently taking the brand name drug. If you are taking the brand name drug or original biological product you at the time we make the change, we will provide you with information about the specific change(s). This will also include information on the steps you may take to request an exception to cover the brand name drug. You may not get this notice before we make the change.
 - You or your prescriber can ask us to make an exception and continue to cover the brand name drug or original biological product for you. For information on how to ask for an exception, see Chapter 9.
- **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 are taking that drug, we will tell you right away.
 - Your prescriber will also know about this change and can work with you to find another drug for your condition.
- **Other changes to drugs on the "Drug List"**
 - We may make other changes once the year has started that affect drugs you are taking. For example, we might add a generic drug that is not new to the market to replace a brand name drug on the "Drug List" or change the cost sharing tier or add new restrictions to the brand name drug or both. We also might make changes based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
 - For these changes, we must give you at least 30 days' advance notice of the change or give you notice of the change and a 31-day refill of the drug you are taking at a network pharmacy.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

- After you receive notice of the change, you should work with your provider to switch to a different drug that we cover or to satisfy any new restrictions on the drug you are taking.
- You or your prescriber can ask us to make an exception and continue to cover the drug for you. For information on how to ask for an exception, see Chapter 9.

Changes to the "Drug List" that do not affect you during this plan year

We may make certain changes to the "Drug List" that are not described above. In these cases, the change will not apply to you if you are 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 will not 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 are taking (except for market withdrawal, a generic drug replacing a brand name drug, or other change noted in the sections above), then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restrictions to your use of the drug.

We will not tell you about these types of changes directly during the current plan year. You will 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 the drugs you are taking that will impact you during the next plan year.

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are excluded. This means Medicare does not 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 applicable). If you appeal and the requested drug is found not to be excluded under Part D, we will pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States or its territories.
- Our plan usually cannot cover off-label use. **Off-label** use is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

- Coverage for off-label use is allowed only when the use is supported by certain references, such as the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.

In addition, by law, the following categories of drugs are not 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 seeks to require that associated tests or monitoring services be purchased exclusively 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.)

In addition, if you are **receiving “Extra Help” from Medicare** to pay for your prescriptions, the “Extra Help” program will not pay for the drugs not normally covered. However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (Please refer to the **Agency Contact Information** in the back of this booklet for a list of Medicaid contact information by state.)

SECTION 8 Filling a prescription

Section 8.1 Provide your membership information

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

Section 8.2 What if you don't have your membership information with you?

If you don't have your plan membership information with you when you fill your prescription, you or the pharmacy can call the plan to get the necessary information, or you can ask the pharmacy to look up your plan enrollment information.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

If the pharmacy is not able to 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. See Chapter 7, Section 2 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations**Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?**

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

Section 9.2 What if you're 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 of its residents. If you are a resident of a LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it is part of our network.

Check your *Provider/Pharmacy Directory* to find out if your LTC facility's pharmacy or the one that it uses is part of our network. If it isn't, or if you need more information or assistance, please contact Member Service. If you are in an LTC facility, we must ensure that you are able to routinely receive your Part D benefits through our network of LTC pharmacies.

What if you're a resident in a long-term care (LTC) facility and need a drug that is not on our "Drug List" or is restricted in some way?

Please refer to Section 5.2 about a temporary or emergency supply.

Section 9.3 What if you're also getting drug coverage from an employer or retiree group plan?

If you currently have other prescription drug coverage through your (or your spouse or domestic partner's) employer or retiree group, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription 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 would pay first.

Special note about creditable coverage:

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

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

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

Keep this notice about creditable coverage because you may need it later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get the creditable coverage notice, request a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Hospice and our plan do not cover the same drug at the same time. If you are enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea drugs, laxatives, pain medication or anti-anxiety drugs) that are not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive 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 receiving 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

Section 10.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting 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 such as:

- Possible medication errors
- Drugs that may not be necessary because you are taking another 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 are allergic to
- Possible errors in the amount (dosage) of a drug you are taking
- Unsafe amounts of opioid pain medications

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

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

Section 10.2 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 doctors or pharmacies, or if you had a recent opioid overdose, we may talk to your doctors to make sure your use of opioid medications is appropriate and medically necessary. Working with your doctors, 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 may get these medications or how much you can get, we will send you a letter in advance. The letter will tell you if we will limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific doctor or pharmacy. You will have an opportunity to tell us which doctors 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 will 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 will review your case and give you a new decision. If we continue to deny any part of your request related to the limitations that apply to your access to medications, we will automatically send your case to an independent reviewer outside of our plan. See Chapter 9 for information about how to ask for an appeal.

You will not be placed in our DMP if you have certain medical conditions, such as active cancer-related pain or sickle cell disease, you are receiving hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.3 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 that our members get the most benefit from the drugs they take.

CHAPTER 5. Using the plan's coverage for your Part D prescription drugs

Some members who take medications for different medical conditions and have high drug costs or are in a DMP to help members use their 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 receive 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. Also, 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 will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you. If you have any questions about this program, please contact Member Service.

CHAPTER 6:

*What you pay for your Part D
prescription drugs*

CHAPTER 6. What you pay for your Part D prescription drugs

Are you currently getting help to pay for your drugs?

If you are 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, please call Member Service and ask for the LIS Rider.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for Part D prescription drugs. To keep things simple, we use *drug* in this chapter to mean a Part D prescription drug. As explained in Chapter 5, 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, Sections 1 through 4 explain these rules. When you use the plan's "Real-Time Benefit Tool" to look up drug coverage (see Chapter 3, Section 3.3), the cost shown is provided in "real time" meaning the cost you see in the tool reflects a moment in time to provide an estimate of the out-of-pocket costs you are expected to pay. You can also obtain information provided by the "Real Time Benefit Tool" by calling Member Service.

Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

There are different types of out-of-pocket costs for Part D drugs. The amount that you pay for a drug is called **cost sharing** and there are three ways you may be asked to pay.

- **Deductible** is the amount you pay for drugs before our plan begins to pay its 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 1.3 How Medicare calculates your out-of-pocket costs

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

CHAPTER 6. What you pay for your Part D prescription drugs

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 Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5):

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage (if applicable)
 - The Initial Coverage Stage
 - The Coverage Gap Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included in your out-of-pocket costs* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some payments made by the Medicare Coverage Gap Discount Program are included in your out-of-pocket costs. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$8,000 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage. **Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.**

These payments are not included in your out-of-pocket costs

Your out-of-pocket costs **do not include** any of these types of payments:

- Your monthly premium, if applicable.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your brand or generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.

CHAPTER 6. What you pay for your Part D prescription drugs

- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan by calling Member Service.

How can you keep track of your out-of-pocket total?

- **We will help you.** The Part D Explanation of Benefits (EOB) report you receive includes the current amount of your out-of-pocket costs. When this amount reaches \$8,000, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

SECTION 2 What you pay for a drug depends on which drug payment stage you are in when you get the drug

Section 2.1 What are the drug payment stages for Freedom Blue PPO members?

There are four **drug payment stages** for your prescription drug coverage under Freedom Blue PPO. How much you pay depends on what stage you are in when you get a prescription filled or refilled. Details of each stage are in Sections 4 through 7 of this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Coverage Gap Stage

Stage 4: Catastrophic Coverage Stage

Important Message About What You Pay for Insulin - You won't pay more than \$35 for a one-month supply of each insulin product covered by our plan, no matter what cost sharing tier it's on, even if you haven't paid your deductible (if applicable). Please see your *Part D Prescription Drugs* appendix for your specific cost sharing.

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 Change (ANOC) you receive during the Annual Election Period.

CHAPTER 6. What you pay for your Part D prescription drugs**SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in****Section 3.1 We send you a monthly summary called the *Part D Explanation of Benefits* (the Part D EOB)**

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **Out-of-Pocket Costs**.
- We keep track of your **Total Drug Costs**. This is the amount you pay out-of-pocket, or others pay on your behalf, plus the amount paid by the plan.

If you have had one or more prescriptions filled through the plan during the previous month, we will send you a Part D EOB. The Part D EOB includes:

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

Section 3.2 Help us keep our information about your drug payments up to date

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

- **Show your membership card every time you get a prescription filled.** This helps us make sure we know about the prescriptions you are filling and what you are paying.
- **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 will not 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. Here are 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 using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.

CHAPTER 6. What you pay for your Part D prescription drugs

- Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.
- If you are 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 have made for you.** Payments made by certain other individuals 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 most 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 receive 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 any questions, please call us at Member Service. Be sure to keep these reports.

SECTION 4 During the Deductible Stage, you pay the full cost of your drugs (if applicable)

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

SECTION 5 During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription 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.

CHAPTER 6. What you pay for your Part D prescription drugs

The plan has five cost sharing tiers

Every drug on the 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.
- 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.

Your cost for insulin will be no more than \$35 per month supply of each covered product on any tier.

To find out which cost sharing tier your drug is in, look it up in the 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 is not in the plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 to find out when we will cover a prescription filled at an out-of-network pharmacy.
- The plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 and the plan's *Provider/Pharmacy Directory*.

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 <i>one-month</i> supply of a drug
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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 9 of this chapter for more information on Part D vaccines cost sharing for Part D Vaccines.

CHAPTER 6. What you pay for your Part D prescription drugs**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 prescription 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 are 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 of your drugs, if this will help you better plan refill dates for different prescriptions.

If you receive less than a full month's supply of certain drugs, you will not have to pay for the full month's supply.

- If you are 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 are responsible for a copayment for the drug, you will only pay for the number of days of the drug that you receive instead of a whole month. We will 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 receive.

Section 5.4 Your costs for a *long-term* (up to a 90-day) supply of a drug

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

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 total drug costs for the year reach \$5,030

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled reaches the **\$5,030 limit for the Initial Coverage Stage**.

The Part D EOB that you receive will help you keep track of how much you, the plan, and any third parties have spent on your behalf during the year. Many people do not reach the \$5,030 limit in a year.

We will let you know if you reach this amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage. See Section 1.3 on how Medicare calculates your out-of-pocket costs.

CHAPTER 6. What you pay for your Part D prescription drugs

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 Costs in the Coverage Gap Stage

Your level of coverage during the Coverage Gap Stage is determined by your specific group benefit plan.

If applicable, when you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price and a portion of the dispensing fee for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and move you through the coverage gap.

If your group does not provide additional coverage when you are in the Coverage Gap Stage, you still receive some coverage for generic drugs. You pay no more than 25% of the cost for generic drugs and the plan pays the rest. Only the amount you pay counts and moves you through the coverage gap.

If your group provides additional coverage during the Coverage Gap Stage, you will pay the amounts listed in the *Part D Prescription Drugs* appendix. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You continue paying these costs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. Once you reach this amount \$8,000, you leave the Coverage Gap Stage and move to the Catastrophic Coverage Stage.

Medicare has rules about what counts and what does *not* count toward your out-of-pocket costs (Section 1.3).

Please refer to the *Part D Prescription Drugs* appendix for details on your specific coverage.

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You enter the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$8,000 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

If applicable, you may have cost sharing for drugs that are covered under our enhanced excluded drug benefit.

CHAPTER 6. What you pay for your Part D prescription drugs

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 8 Part D Vaccines. What you pay for depends on how and where you get them

Important Message About What You Pay for Vaccines - Some vaccines are considered medical benefits. 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. Refer to your plan's "Drug List" or contact Member Services for coverage and cost sharing details about specific vaccines.

There are two parts to our coverage of Part D vaccinations:

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

Your costs for a Part D vaccination depend on three things:

- 1. Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
 - Most adult Part D vaccinations 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 another. Alternatively, a provider may give it in the doctor's office.

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

- Sometimes when you get a vaccination, you have to pay for 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 will be reimbursed the entire cost you paid.
- Other times, when you get a vaccination, you will pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you will pay nothing.

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

CHAPTER 6. What you pay for your Part D prescription drugs

- Situation 1:* You get the Part D vaccination 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 will pay nothing.
 - For other Part D vaccines, you will 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 vaccination at your doctor's office.
- When you get the vaccine, you may have to pay for 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 that are described in Chapter 7.
 - For most adult Part D vaccines, you will 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.)
- Situation 3:* You buy the Part D vaccine itself at the network pharmacy, and then take it to your doctor's office where they give you the vaccine.
- For most adult Part D vaccines, you will pay nothing for the vaccine itself.
 - For other Part D vaccines, you will 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 will be reimbursed the full amount you paid. For other Part D vaccines, you will be reimbursed the amount you paid less any coinsurance for the vaccine administration.
 - 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
you have received for covered
medical services or drugs*

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**SECTION 1 Situations in which you should ask us to pay our share of the cost of your 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 find that you have paid more than you expected under the coverage rules of the plan. Or you may receive a bill from a provider. In these cases, you can ask our plan to pay you back (paying you back is often called reimbursing you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan. There may be deadlines that you must meet to get paid back. Please see 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 have received or possibly for more than your share of cost sharing as discussed in the document. First try to resolve the bill with the provider. If that does not work, send the bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly. If we decide not to pay it, we will 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.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received:

1. When you've received medical care from a provider who is not in our plan's network

When you received care from a provider who is not part of our network, you are 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 the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive 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 have made.
- You may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- Please 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 cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the 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.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

- 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 are retroactively enrolled in our plan

Sometimes a person's enrollment in the 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 will 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 get a prescription filled

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 will 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. See Chapter 5, Section 2.5 for a discussion of these circumstances.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot 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.

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.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

- 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.

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.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 (What to do if you have a problem or complaint (coverage decisions, appeals, complaints)) of this document has information about how to make an appeal.

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

You may request 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 received 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.
- Either download a copy of the form from our website ([medicare.highmark.com](https://www.medicare.highmark.com)) or call Member Service and ask for the form.

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

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

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs**SECTION 3 We will consider your request for payment and say yes or no****Section 3.1 We check to see whether we should cover the service or drug and how much we owe**

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

- If we decide that the medical care or drug is covered and you followed all the rules, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider.
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. We will send you a letter explaining the reasons why we are not sending the payment and your right to appeal that decision.

Section 3.2 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 have made a mistake in turning down your request for payment or the amount we are paying, you can make an appeal. If you make an appeal, it means you are 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 of this document.

CHAPTER 8:

Your rights and responsibilities

CHAPTER 8. Your rights and responsibilities**SECTION 1 Our plan must honor your rights and cultural sensitivities as a member of the plan****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.)**

Your 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 a plan may meet these accessibility requirements include, but are not 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 are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member 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 the plan's network for a specialty are not available, it is the plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you will only pay in-network cost sharing. If you find yourself in a situation where there are no specialists in the plan's network that cover a service you need, call the plan for information on where to go to obtain this service at in-network cost sharing.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Service at 1-800-550-8722. You may 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 that you get timely access to your covered services and drugs

You have the right to choose a provider for your care.

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.

CHAPTER 8. Your rights and responsibilities

If you think that you are not 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 are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.

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

You have the right to look at your medical records held by the plan, and to get a copy of your records. We are 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 will 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 are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Member 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

CHAPTER 8. Your rights and responsibilities

phone. You can also read our Notice of Privacy Practices (NPP) on our website. Log onto [medicare.highmark.com](https://www.medicare.highmark.com) and click on “Privacy Policy and Notice of Privacy Practices” at the bottom of the page. To download a copy, click on “Highmark Inc. NPP”. You can also call Member Service at the number listed on your ID card to request a copy of our NPP.

Section 1.4 We must give you information about the plan, its 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, please call Member Service.

- **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 prescription 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 We must support your right to make decisions about your care**You have the right to know your treatment options and participate in decisions about your health 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 of your choices.** You have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are 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.

CHAPTER 8. Your rights and responsibilities

- **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. Of course, 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 that, *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.

The legal documents that you can use to give your directions in advance of these situations are called **advance directives**. There are different types of advance directives and different names for them. Documents called **living will** and **power of attorney for health care** are examples of advance directives.

If you want to use an **advance directive** to give your instructions, here is what to do:

- **Get the form.** You can get an advance directive form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should 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 are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

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

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

CHAPTER 8. Your rights and responsibilities

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may 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

<p>Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made</p>
--

If you have any problems, concerns, or complaints and need to request 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 are required to treat you fairly.**

<p>Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?</p>

If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Member Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.

CHAPTER 8. Your rights and responsibilities

- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 1.8 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Member Service**.
- You can **call the SHIP**. For details, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication “Medicare Rights & Protections.” (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 1-877-486-2048).

SECTION 2 You have some responsibilities as a member of the plan

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member 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 is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services.
 - Chapters 5 and 6 give the details about your Part D prescription drug coverage.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription 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 that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect all 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.

CHAPTER 8. Your rights and responsibilities

- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums (if applicable).
 - You must continue to pay your Medicare Part B premiums to remain a member of the plan.
 - For most of your medical services or drugs covered by the 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 prescription drug coverage.
 - If you are 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 remain a member of the 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* of our plan service area, you cannot remain a member of our plan.**
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board).

CHAPTER 9:

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

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

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern
--

This chapter explains two 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 of these 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 guide in Section 3 will help you identify the right process to use and what you should do.

Section 1.2 What about the 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 and can be hard to understand. To make things easier, this chapter:

- Uses simpler words in place of certain legal terms. For example, this chapter generally says making a complaint rather than filing a grievance, coverage decision rather than organization determination, or coverage determination or at-risk determination, and independent review organization instead of Independent Review Entity.
- It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms. Knowing which terms to use will help you communicate more accurately to get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 Where to get more information and personalized assistance

We are always available to help you. Even if you have a complaint about our treatment of you, we are obligated to honor your right to complain. Therefore, you should always reach out to Member Service for help. But in some situations, you may also want help or guidance from someone who is not connected with us. Below are two entities that can assist you.

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 are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

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

Medicare

You can also contact Medicare to get help. To contact Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can also visit the Medicare website (www.medicare.gov).

SECTION 3 To deal with your problem, which process should you use?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

Is your problem or concern about your benefits or coverage?

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

Yes.

Go on to the next section of this chapter, **Section 4, A guide to the basics of coverage decisions and appeals.**

No.

Skip ahead to **Section 10** at the end of this chapter: **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 the basics of coverage decisions and appeals

Section 4.1 Asking for coverage decisions and making appeals: the big picture

Coverage decisions and appeals deal with problems related to your benefits and coverage for your medical care (services, items and Part B prescription drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B prescription drugs as

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

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 prior to receiving benefits

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical care. For example, if your plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either your network doctor can show that you received 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 will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical care before you receive it, you can ask us to make a coverage decision for you. 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 will send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide medical care is not covered or is no longer covered by Medicare 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 a benefit is received, and you are not satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made. Under certain circumstances, which we discuss later, you can request 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 were properly following the rules. When we have completed 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 will 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 that is not connected to us.

- You do not 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 do not fully agree with your Level 1 appeal.

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

- See **Section 6.4** of this chapter for more information about Level 2 appeals.
- For Part D drug appeals, if we say no to all or part of your appeal, you will need to ask for a Level 2 appeal. Part D appeals are discussed further in Section 7 of this chapter.

If you are not satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (Section 9 in this chapter explains the Level 3, 4, and 5 appeals processes).

<h3>Section 4.2 How to get help when you are asking for a coverage decision or making an appeal of a coverage decision</h3>
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Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Member Service.**
- **You can 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 will need to be appointed as your representative. Please call Member Service and ask for the *Appointment of Representative* form. (The form is also available on Medicare’s website 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 prescription drugs, your doctor can request 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 prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied your doctor or prescriber can request a Level 2 appeal.
- **You can ask someone to act on your behalf.** If you want to, 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 Service and ask for the *Appointment of Representative form*. (The form is also available on Medicare’s website at www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at medicare.highmark.com). The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
 - While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will 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 may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 4.3 Which section of this chapter gives the details for your situation?**

There are four different situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- **Section 5** of this chapter: Your medical care: How to ask for a coverage decision or make an appeal
- **Section 6** of this chapter: Your Part D prescription drugs: How to ask for a coverage decision or make an appeal
- **Section 7** of this chapter: How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon
- **Section 8** of this chapter: 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 Service. You can also get help or information from government organizations such as your SHIP.

SECTION 5 Your medical care: How to ask for a coverage decision or make an appeal of a coverage decision

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

This section is about your benefits for medical care. These benefits are described in the *Medical Benefits Chart* appendix. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

This section tells what you can do if you are in any of the five following situations:

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

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

5. You are being told that coverage for certain medical care you have 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, you need to read Sections 7 and 8 of this Chapter. Special rules apply to these types of care.

Section 5.2 Step-by-step: How to ask for a coverage decision

Legal Terms

<p>When a coverage decision involves your medical care, it is called an organization determination. A fast coverage decision is called an expedited determination.</p>
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Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 14 days 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. In order to get a fast coverage decision, you must meet two requirements:

- You may *only* ask for coverage for medical items and/or services (not requests for payment for items and/or services already received).
- 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 requested.

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

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

This means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a **Medicare Part B prescription drug**, we will give you an answer **within 72 hours** after we receive 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 days** if your request is for a medical item or service. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. We will 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. See Section 10 of this chapter for information on complaints.)

For Fast Coverage decisions we use an expedited timeframe

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

- **However**, if you ask for more time, or if we need more that may benefit you **we can take up to 14 more days**. If we take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
- If you believe we should *not* take extra days, you can file a fast complaint. (See Section 10 of this chapter for information on complaints.) We will call you as soon as we make the decision.
- **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.

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 Step-by-step: How to make a Level 1 appeal

Legal Terms

An appeal to the 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 days or 7 days for Part B drugs. A fast appeal is generally made within 72 hours.

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we will 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 of this chapter.

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 60 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 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 of the information. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if needed, possibly contacting you or your doctor.

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.
 - 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 will tell you in writing. We can't take extra time if your request is for a Medicare Part B prescription drug.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on 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 requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

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

- **If our answer is no to part or all of what you requested**, we will send you our decision in writing and automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it receives your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we receive your appeal. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. We will 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 will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
 - If you believe we should *not* take extra days, you can file a fast complaint. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (See Section 10 of this chapter for information on complaints.)
 - If we do not give you an answer by the deadline (or by the end of the extended time period), we will 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 requested**, 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 Medicare Part B prescription drug.
- **If our plan says no to part or all of your appeal**, we will automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 Step-by-step: How a Level 2 appeal is done

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.**

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

- 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 of the information related to 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 receives your appeal.
- However, 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 Medicare Part B prescription 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 review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it receives your appeal.
- However, 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 Medicare Part B prescription 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 review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug within **72 hours** after we receive the decision from the review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we receive the decision from the 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:
 - Explaining its decision.

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

- Notifying you of the 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.
- Telling 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 in this chapter explains the Level 3, 4, and 5 appeals processes.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you have received 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 are asking for a coverage decision. To make this decision, we will check to see if the medical care you paid for is a covered service. We will also check to see if you followed all the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed all the rules, we will send you the payment for our share of the cost within 60 calendar days after we receive your request. If you haven't paid for the medical care, we will 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 will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why.

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are 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 that we describe in Section 5.3. For appeals concerning reimbursement, please note:

- We must give you our answer within 60 calendar days after we receive your appeal. If you are asking us to pay you back for medical care you have already received and paid for, you are not allowed to ask for a fast appeal.

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

- 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 requested to you or to the provider within 60 calendar days.

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

Section 6.1 This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (See Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs please see 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 is not on the plan's *List of Covered Drugs (Formulary)*. **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). **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**

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

If you disagree with a coverage decision we have 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 What is an exception?

Legal Terms

Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **formulary exception**.

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **formulary exception**.

Asking to pay a lower price for a covered non-preferred drug is sometimes called asking for 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 for you that is 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 copayment or coinsurance amount we require you to pay for the drug.
3. **Changing coverage of a drug to a lower cost sharing tier.** Every drug on our "Drug List" is in one of 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 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.

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

- 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 for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our "Drug List" 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 Step-by-step: 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 receive your doctor's statement.

Fast coverage decisions are made within **24 hours** after we receive 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 have not yet received*. (You cannot 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.

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

- **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: Request a standard coverage decision or a 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 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. Chapter 2 has contact information. To assist us in processing your request, please be sure to include your name, contact information, and information identifying which denied claim is being appealed.

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

- **If you are requesting 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

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

- 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 Step-by-step: How to make a Level 1 appeal

Legal Terms

<p>An appeal to the plan about a Part D drug coverage decision is called a plan redetermination. A fast appeal is also called an expedited redetermination.</p>

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

A standard appeal is usually made within 7 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**.

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

- **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 Coverage Determination Request Form, which is available on our website. 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 60 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.

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

- **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 Step-by-step: 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 review organization. If, however, we did not complete our review within the applicable timeframe, or make an unfavorable decision regarding **at-risk** determination under our drug management program, we will automatically forward your claim 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.**

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

- 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:

- Explaining its decision.
- Notifying you of the right to a Level 3 appeal if the dollar value of the drug coverage you are requesting meets a certain minimum. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final.
- Telling you the dollar value that must be in dispute to continue with the appeals process.

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

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 are 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.

<h4>Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights</h4>
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Within two days of being admitted to the hospital, you will 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 do not get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, please call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY 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.

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

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 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, you can call Member Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

Section 7.2 Step-by-step: How to make a Level 1 appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer 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 at any time, please call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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:

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

- 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**, and 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.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

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 Service or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.

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?

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

- 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 Step-by-step: 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 their 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 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 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.

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

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 7.4 What if you miss the deadline for making your Level 1 appeal to change your hospital discharge date?

Legal Terms

A fast review (or fast appeal) is also called an **expedited appeal**.

You can appeal to us instead

As explained above, you must act quickly to start your Level 1 appeal of your hospital discharge date. If you miss the deadline for contacting the Quality Improvement Organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 *Alternate* appeal

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We see if the decision about when you should leave the hospital was fair and followed all the rules.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date. We will keep providing your covered inpatient hospital services for as long as they are medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

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

- **If we say no to your appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
 - If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

Step-by-Step: Level 2 Alternate 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 our plan 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: We will automatically forward your case to the independent review organization.

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must pay you back for our share of the costs of hospital care you received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal**, it means they agree that your planned hospital discharge date was medically appropriate.
 - The written notice you get from the independent review organization will tell how to start a Level 3 appeal with the review process, which is handled by an Administrative Law Judge or attorney adjudicator.

Step 3: If the independent review organization turns down your appeal, you choose whether you want to take your appeal further.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 appeal, you decide whether to accept their decision or go on to Level 3 appeal.
- 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

Section 8.1 This section is only about three services: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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 8.2 We will tell you in advance when your coverage will be ending

Legal Terms

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

1. **You receive a notice in writing** at least two 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.

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

- 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 not mean you agree** with the plan's decision to stop care.

Section 8.3 Step-by-step: 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 at any time, please call Member Service. Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance.

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 for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

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 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 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 8.4 Step-by-step: 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

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

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 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 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.*What happens if the 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 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 8.5 What if you miss the deadline for making your Level 1 appeal?**You can appeal to us instead**

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

Step-by-Step: How to make a Level 1 *Alternate Appeal*

Legal Terms

A fast review (or fast appeal) is also called an **expedited appeal**.

Step 1: Contact us and ask for a fast review.

- **Ask for a fast review.** This means you are asking us to give you an answer using the fast deadlines rather than the standard deadlines. Chapter 2 has contact information.

Step 2: We do a fast review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

Step 3: We give you our decision within 72 hours after you ask for a fast review.

- **If we say yes to your appeal,** it means we have agreed with you that you need services longer and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get 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, then **you will have to pay the full cost** of this care.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

Legal Terms

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

Step-by-Step: Level 2 *Alternate Appeal Process*

During the Level 2 appeal, the **independent review organization** reviews the decision we made to your fast appeal. This organization decides whether the decision should be changed. **The independent review organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the independent review organization. Medicare oversees its work.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Step 1: We automatically forward your case to the independent review organization.**

- We are required to send the information for your Level 2 appeal to the independent review organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. Section 10 of this chapter tells how to make a complaint.)

Step 2: The independent review organization does a fast review of your appeal. The reviewers give you an answer within 72 hours.

- Reviewers at the independent review organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal**, then we must pay you back for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover services.
- **If this organization says *no* to your appeal**, it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the independent review organization will tell you in writing what you can do if you wish to go on to a Level 3 appeal.

Step 3: If the independent review organization says no to your appeal, you choose 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.
- A Level 3 appeal is reviewed 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 Level 3 and beyond

Section 9.1 Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have 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 cannot appeal any further. The written response you receive to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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

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.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**Section 9.2 Appeal Levels 3, 4 and 5 for Part D Drug Requests**

This section may be appropriate for you if you have made a Level 1 appeal and a Level 2 appeal, and both of your appeals have been turned down.

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive 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 three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

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

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.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**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 the customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	<ul style="list-style-type: none"> • Has someone been rude or disrespectful to you? • Are you unhappy with our Member Service? • Do you feel you are being encouraged to leave the plan?
Waiting times	<ul style="list-style-type: none"> • 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 Service or other staff at the plan? <ul style="list-style-type: none"> ◦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • 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 <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>If you have asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can make a complaint about our slowness. Here are examples:</p> <ul style="list-style-type: none"> • 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.

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

Complaint	Example
	<ul style="list-style-type: none"> • 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 also called **filing a grievance**.
- **Using the process for complaints** is also called **using the process for filing a grievance**.
- A **fast complaint** is also called an **expedited grievance**.

Section 10.3 Step-by-step: Making a complaint**Step 1: Contact us promptly – either by phone or in writing.**

- **Usually, calling Member Service is the first step.** If there is anything else you need to do, Member Service will let you know.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
 - **The Standard Grievance Procedure is as follows:**

Your initial inquiry should be directed to the Member Service 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

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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 Service 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 10.4 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.

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Or

- **You can make your complaint to both the Quality Improvement Organization and us at the same time.**

Section 10.5 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/MedicareComplaintForm/home.aspx. You may also call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

CHAPTER 10:

*Ending your membership in the
plan*

CHAPTER 10. Ending your membership in the plan

SECTION 1 Introduction to 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 Annual Enrollment Period

You can end your membership in our plan during the **Annual Enrollment Period** (also known as the **Annual Open Enrollment Period**). During this time, review your health and drug coverage and decide about coverage for the upcoming year.

- **The Annual 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 prescription drug coverage.
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - If you choose this option, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription 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 begins on January 1.

CHAPTER 10. Ending your membership in the plan**Section 2.2 You can end your membership during the Medicare Advantage Open Enrollment Period**

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **The annual Medicare Advantage Open Enrollment Period** is from January 1 to March 31.
- **During the annual Medicare Advantage Open Enrollment Period** you can:
 - Switch to another Medicare Advantage Plan with or without prescription drug coverage.
 - Disenroll from our plan and obtain 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.
- **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 prescription 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 the plan, call Medicare, or visit the Medicare website (www.medicare.gov):

- Usually, when you have moved.
- If you have Medicaid.
- If you are eligible for “Extra Help” with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are 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.

The enrollment time periods vary depending on your situation.

To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. You can choose:

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- Another Medicare health plan with or without prescription drug coverage.
- Original Medicare *with* a separate Medicare prescription drug plan.
- Or Original Medicare *without* a separate Medicare prescription drug plan.

Note: If you disenroll from Medicare prescription 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 your request to change your plan is received.

If you receive “Extra Help” from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions about ending your membership you can:

- **Call Member Service.**
- Find the information in the *Medicare & You 2024* handbook.
- Contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY 1-877-486-2048).

SECTION 3 How do you end your membership in our plan?

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. • You will automatically be disenrolled from Freedom Blue PPO when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Service if you need more information on how to do this.

CHAPTER 10. Ending your membership in the plan**If you would like to switch from our plan to:****This is what you should do:**

- You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.
- You will be disenrolled from Freedom Blue PPO when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan

Until your membership ends, and your new Medicare coverage begins, 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 are hospitalized on the day that your membership ends, your hospital stay will be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Freedom Blue PPO must end your membership in the plan in certain situations**Section 5.1 When must we end your membership in the plan?**

Freedom Blue PPO must end your membership in the 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 Service 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.)

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- 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 are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership call Member Service.

Section 5.2 We cannot ask you to leave our plan for any health-related reason

Freedom Blue PPO is not allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week (TTY 1-877-486-2048).

Section 5.3 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

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, or 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 are not included or explained in this document.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, sexual orientation, 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, please 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 <https://www.hhs.gov/ocr/index.html>.

If you have a disability and need help with access to care, please call us at Member Service. If you have a complaint, such as a problem with wheelchair access, Member Service can help.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare 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

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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

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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.

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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

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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 Coverage*.

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- **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 Service.

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.

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Definitions of important words

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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 does not exceed 24 hours.

Annual 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.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost sharing amount. As a member of Freedom Blue PPO, you only have to pay our plan's cost sharing amounts when you get services covered by our plan. We do not allow providers to **balance bill** or otherwise charge you more than the amount of cost sharing your 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 have not received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There 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 cannot be copied exactly, so alternative forms are called biosimilars. Biosimilars generally work just as well, and are as safe, as the original biological products.

Biosimilar – A prescription drug that is considered to be very similar, but not identical, to the original biological product. Biosimilars generally work just as well, and are as safe, as the original biological product; however, biosimilars generally require a new prescription to substitute for the original biological product.

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 \$8,000 for Part D covered drugs during the covered year. During this payment stage, the plan pays the full cost for your covered Part D drugs. You pay nothing.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare.

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Coinsurance – An amount you may be required to pay, expressed as a percentage (for example 20%) as your share of the cost for services or prescription drugs after you pay any deductibles.

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all Part A and Part B services from both network (preferred) providers and out-of-network (non-preferred) providers. In addition to the maximum out-of-pocket amount for covered Part A and Part B medical services, your plan may also have a maximum out-of-pocket amount for certain types of services (see your *Medical Benefits Chart* appendix).

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 related to quality of care, waiting times, and the customer service you receive. It also includes complaints if your plan does not follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example \$10), rather than a percentage.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to the plan’s monthly premium, if applicable.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed copayment amount that a plan requires when a specific service or drug is received; or (3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is received.

Cost Sharing Tier – Every drug on the list of covered drugs is in one of five cost sharing tiers. In general, the higher the cost sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are 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 your plan, that isn’t a coverage determination. You need to call or write to your 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 of the prescription drugs covered by our plan.

Covered Services – The term we use in this EOC to mean all of 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.

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Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care, provided by people who do not 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 are 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 your plan is 30 days, then your daily cost sharing rate is \$1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

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 are 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 is not on our formulary (a formulary exception), or get a non-preferred drug at a lower cost sharing level (a tiering exception). You may also request an exception if our plan requires you to try another drug before receiving the drug you are requesting, or if our plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

"Extra Help" – A Medicare or a State program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, a generic drug works the same as a brand name drug and usually costs less.

Grievance - A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This does not involve coverage or payment disputes.

Home Health Aide – A person who provides services that do not 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. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your "total drug costs including amounts you have paid and what your plan has paid on your behalf" for the year have reached \$5,030.

Initial Enrollment Period – When you are 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 will pay for covered Part A and Part B services received from network (preferred) providers. After you have reached this limit, you will not 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 covered Part A and Part B medical services, your plan may also have a maximum out-of-pocket amount for certain types of services (see your Medical Benefits Chart appendix).

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan.

Low Income Subsidy (LIS) – See "Extra Help."

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Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books.

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 – A time period from January 1 until March 31 when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain 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 an individual 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 an i) HMO, ii) PPO, a iii) Private Fee-for-Service (PFFS) plan, or a iv) 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 Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D members who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all of the services that are covered by Medicare Part A and B. The term Medicare-Covered Services does not 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 the 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.

CHAPTER 12. Definitions of important words

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 Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – Provider is the general term for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

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 two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that does not have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan.

Out-of-Pocket Costs – See the definition for cost sharing above. A member's cost sharing requirement to pay for a portion of services or drugs received is also referred to as the member's out-of-pocket cost requirement.

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.

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Part C – see 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 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 are first eligible to join a Part D plan.

Preferred Cost Sharing – Preferred cost sharing means lower cost sharing for certain covered Part D drugs at certain network pharmacies.

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 are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received 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 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 services or certain drugs. 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 do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost sharing responsibility is. Covered services that need prior authorization are marked in the *Medical Benefits Chart* appendix. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – Medical devices including, but are not limited to: arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

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Quantity Limits – A management tool that is designed to limit the use of selected drugs 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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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. The plan must disenroll you if you permanently move out of the 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 plan 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 are getting "Extra Help" with your prescription drug costs, 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 reside in a nursing home, or who have certain chronic medical conditions.

Standard Cost Sharing – Standard cost sharing is cost sharing other than preferred cost sharing offered at a network pharmacy.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will 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 are not the same as Social Security benefits.

Urgently Needed Services – Covered services that are not emergency services, provided when the network providers are temporarily unavailable or inaccessible or when the enrollee is out of the service area. For example, you need immediate care during the weekend. Services must be immediately needed and medically necessary.

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. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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:](mailto:CivilRightsCoordinator@highmarkhealth.org)

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 for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Multi-Language Insert Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 (TTY: 711)。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quý vị cần thông dịch viên xin gọi (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quý vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 대해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがあります。通訳をご用命になるには、(TTY:711)にお電話ください。日本語を話す人者が支援いたします。これは無料のサービスです。

Blue Cross Blue Shield Association Network Sharing Counties by State

The following 26 states below participate in the 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 Medicare Advantage PPO Providers only in the counties listed:

State	County
AR	ARKANSAS
AR	ASHLEY
AR	BAXTER
AR	BENTON
AR	BOONE
AR	BRADLEY
AR	CALHOUN
AR	CARROLL
AR	CLARK
AR	CLAY
AR	CLEBURNE
AR	CLEVELAND
AR	COLUMBIA
AR	CONWAY
AR	CRAIGHEAD
AR	CRAWFORD
AR	CRITTENDEN
AR	CROSS
AR	DALLAS
AR	DREW
AR	FAULKNER
AR	FRANKLIN
AR	FULTON
AR	GARLAND
AR	GRANT

State	County
AR	GREENE
AR	HEMPSTEAD
AR	HOT SPRING
AR	INDEPENDENCE
AR	IZARD
AR	JACKSON
AR	JEFFERSON
AR	JOHNSON
AR	LAWRENCE
AR	LEE
AR	LINCOLN
AR	LOGAN
AR	LONOKE
AR	MADISON
AR	MARION
AR	MISSISSIPPI
AR	MONROE
AR	MONTGOMERY
AR	NEVADA
AR	NEWTON
AR	OUACHITA
AR	PERRY
AR	PHILLIPS
AR	PIKE
AR	POINSETT

State	County
AR	POLK
AR	POPE
AR	PRAIRIE
AR	PULASKI
AR	RANDOLPH
AR	SALINE
AR	SCOTT
AR	SEARCY
AR	SEBASTIAN
AR	SHARP
AR	ST. FRANCIS
AR	STONE
AR	UNION
AR	VAN BUREN
AR	WASHINGTON
AR	WHITE
AR	WOODRUFF
AR	YELL
AZ	MARICOPA
AZ	PIMA
CA	ALAMEDA
CA	ALPINE
CA	AMADOR
CA	BUTTE
CA	CALAVERAS

State	County
CA	CALOUASA
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
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
CA	SOLANO
CA	SONOMA

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
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
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

State	County
IL	STEPHENSON
IL	TAZEWELL
IL	UNION
IL	WARREN
IL	WASHINGTON
IL	WAYNE
IL	WHITE
IL	WHITESIDE
IL	WILL
IL	WILLIAMSON
IL	WINNEBAGO
IL	WOODFORD
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

State	County
MA	ESSEX
MA	FRANKLIN
MA	HAMPDEN
MA	HAMPSHIRE
MA	MIDDLESEX
MA	NORFOLK
MA	PLYMOUTH
MA	SUFFOLK
MA	WORCESTER
MD	ANNE ARUNDEL*
MD	BALTIMORE CITY*
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

State	County
MO	CAPE GIRARDEAU
MO	CARROLL
MO	CARTER
MO	Cass
MO	CEDAR
MO	CHARITON
MO	CHRISTIAN
MO	CLARK
MO	CLAY
MO	Clinton
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

State	County
MO	MISSISSIPPI
MO	MONITEAU
MO	MONROE
MO	MONTGOMERY
MO	MORGAN
MO	NEW MADRID
MO	NEWTON
MO	OREGON
MO	OSAGE
MO	OZARK
MO	PEMISCOT
MO	PERRY
MO	PETTIS
MO	HELPS
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

State	County
MO	WASHINGTON
MO	WAYNE
MO	WEBSTER
MO	WRIGHT
MS	CLAY
MS	HANCOCK
MS	HARRISON
MS	HINDS
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

State	County
NE	BOONE
NE	BUFFALO
NE	BURT
NE	BUTLER
NE	CASS
NE	CEDAR
NE	CHASE
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

State	County
NE	MCPHERSON
NE	MERRICK
NE	NANCE
NE	NEMAHA
NE	NUCKOLLS
NE	OTOE
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

State	County
NM	MORA
NM	OTERO
NM	QUAY
NM	RIOARRIBA
NM	ROOSEVELT
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

State	County
OK	HUGHES
OK	JACKSON
OK	JEFFERSON
OK	KAY
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

State	County
OR	MARION
OR	MULTNOMAH
OR	POLK
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

State	County
SD	DAVISON
SD	DAY
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

State	County
TX	BLANCO
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
TX	MILLS

State	County
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

State	County
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
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

State	County
UT	SALT LAKE
UT	SUMMIT
UT	TOOELE
UT	UTAH
UT	WASATCH
UT	WASHINGTON
UT	WEBER
WA	ASOTIN
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

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	1-515-725-2011
Kansas	1-800-860-5260	888-755-5580 TTY: 888-985-9295	1-800-792-4884	NA	1-785-296-6174

	SHIP	QIO	MEDICAID	SPAP	ADAP
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	1-505-827-2435
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 TTY: 855-843-4776	1-800-522-0310	NA	1-405-271-4636
Oregon	1-800-722-4134	888-305-6759	1-800-527-5772	971-673-0144	971-673-0144

	SHIP	QIO	MEDICAID	SPAP	ADAP
		TTY: 855-843-4776			
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	1-340-774-9030	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

Health benefits or health benefit administration may be provided by or through Highmark Senior Health Company. Highmark Blue Shield provides certain administrative communications for this company. Highmark Blue Shield and Highmark Senior Health Company are independent licensees of the Blue Cross Blue Shield Association. 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.

Dental coverage is provided by United Concordia Companies, Inc. United Concordia Companies, Inc. is a separate company that administers Highmark dental services. Vision coverage is provided by Davis Vision, Inc. Davis Vision, Inc. is a separate company that administers Highmark vision benefits. The Onduo Diabetes Management program is made available with support from Onduo. Onduo is a separate company that provides a virtual diabetes care program for Highmark members. SilverSneakers is a registered mark of Tivity Health Inc. Tivity Health Inc., is a separate company that administers the SilverSneakers program. TruHearing is a registered trademark of TruHearing, Inc. Express Scripts is an independent company that administers the pharmacy benefit for your health plan. Vida is a separate company that provides cardiometabolic condition management services for certain eligible members of your health plan.

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.

Freedom Blue PPO Member Service

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 Service 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 booklet.

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