2009 Evidence of Coverage

BlueMedicare℠ HMO
Polk County

A Medicare Advantage HMO Plan

Member Services phone number:
1-800-926-6565
TTY/TDD users call: 711

8:00 a.m. - 9:00 p.m. ET, seven days a week

H1026 035

BlueCross BlueShield of Florida
Health Options®

This is Your 2009 Evidence of Coverage (EOC)

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1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care and drug coverage through our Plan, a Medicare Advantage Health Maintenance Organization (HMO); you are still covered by Medicare, but you are getting your health care and Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need or your prescriptions filled, including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B and not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you are already a member of our plan.. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

The geographic service area for our Plan.

The county in our service area is listed below:

Polk County

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage, including the Primary Care Physician you chose and other information. Doctors, hospitals, pharmacists and other network providers use your membership record to know what services or drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership cards

While you are a member of our Plan, you must use our membership cards for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items or drugs. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership cards while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership cards that we gave you at all times and remember to show your cards when you get covered services, items and drugs. If your membership cards are damaged, lost, or stolen, call Member Services right away and we will send you new cards.

The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers. If you don't have the Provider Directory, you can get a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. Member Services can give you the most up-to-date information about changes in our network providers and about which ones are accepting new patients. A complete list of network providers is available on our website at **www.bcbsfl.com**.

You must use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care out-of-area, or for out of the area dialysis services. See the benefits chart in Section 10 for more specific out-of-network coverage information.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website at **www.bcbsfl.com**.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
    - **Amount Paid For Prescriptions-**The amounts paid that count towards your initial coverage limit.
    - **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage-**The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your coinsurance or copayments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information)."

As a member of our Plan, you pay:

1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is $96.40 in 2008. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

   Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than $82,000, or if you are married (file a joint tax return) and your yearly income is more than $164,000.)

If your Yearly Income is*		**In 2008, you pay***
File individual tax return	File joint tax return	
$82,000 or below	$164,000 or below	$96.40
$82,001-$102,000	$164,001-$204,000	$122.20
$102,001-$153,000	$204,001-$306,000	$160.90
$153,001-$205,000	$306,001-$410,000	$199.70
Above $205,000	Above $410,000	$238.40

   ***The above income and Part B premium amounts are for 2008 and will change for 2009.** If you pay a Part B late-enrollment penalty, the premium amount is higher.

2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is $30.36). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

If you have a late enrollment penalty, call Member Services for more information on your monthly plan premium payment options.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help

What extra help is available to help pay my plan costs?

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 will get help paying for any Medicare drug plan's monthly premium and prescription copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.
2. **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than $15,315 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit **www.socialsecurity.gov** on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

What if you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow 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.

<u>If you cannot provide evidence of eligibility for extra help</u>:

- We will ask you or your representative (for example, your pharmacist) for certain information, including when you will run out of your medication.
- We will submit your request to the Centers for Medicare & Medicaid Services (CMS), the federal agency that administers Medicare, within one business day of receiving it. CMS will contact your state Medicaid office to determine your status and let us know the results before the date you indicated you would run out of medicine or within ten days, whichever comes first.
- If you have less than three days of medication left, CMS will contact your state Medicaid office within one day of receiving the request we submitted on your behalf and will inform us of the results within one business day of receiving a response from the state.
- We will attempt to notify you of the results of CMS' inquiry within one business day of receiving them. If we are not able to contact you the first time we try, we will make up to three more attempts to notify you. Our fourth attempt will be in writing. Our notice will include contact information for CMS in case you do not agree with the results of the inquiry.
- We will provide your medication at a reduced cost-sharing level as soon as we find out you are eligible for extra help with your prescription costs.

<u>If you have evidence of eligibility for extra help</u>:

We must accept any of the following types of evidence as proof that you are eligible for extra help. Evidence may be provided by you or your pharmacist, advocate, representative, family member or other individual acting on your behalf:

1. A copy of your Medicaid card including your name and an eligibility date after June of the previous calendar year;

2. A copy of a state document that confirms active Medicaid status after June of the previous calendar year;
3. A print-out from your state's electronic enrollment file showing Medicaid status after June of the previous calendar year;
4. A screen print from your state's Medicaid systems showing Medicaid status after June of the previous calendar year;
5. Other state documentation showing Medicaid status after June of the previous calendar year;
6. If you applied for extra help and were found to be eligible, a copy of the Social Security Administration award letter.

We must also accept the following types of evidence that you are institutionalized and qualify for zero cost-sharing:

1. A remittance from the facility showing Medicaid payment for you for a full month after June of the previous calendar year;
2. A copy of a state document that confirms Medicaid payment to the facility on your behalf for a full month after June of the previous calendar year;
3. A screen print from your state's Medicaid systems showing your institutional status based on a stay of at least a full month for Medicaid payment purposes after June of the previous calendar year.

As soon as you or an individual acting on your behalf presents any of these forms of evidence, we will provide you covered Part D drugs at the appropriate reduced cost-sharing level.

Please send your evidence to Member Services at the address listed in Section 8. You must submit evidence no later than 30 days after the date you went to get your prescription. If you have any questions about these requirements, please call Member Services for assistance.

When we receive the evidence showing your copayment level, we will update our system or implement other procedures so that you can pay the correct copayment when you get your next prescription at the pharmacy. Please be assured that 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. Of course, 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 payment directly to the state. Please contact Member Services if you have questions.

Important Information

We will send you a Prescription Drug Coverage Survey so that we can know what other health and/or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health and/or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health and/or prescription drug coverage, please call Member Services to update your membership records.

2. How You Get Care and Prescription Drugs

How You Get Care

What are "providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are "network providers"?

A provider is a "network provider" when they participate in our Plan. When we say that network providers "participate in our Plan," this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as "plan providers."

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 10.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Member Services or send the bill to us for payment.

Choosing Your Primary Care Physician (PCP)

What is a "PCP"?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan and help you arrange such services. This includes:

- your x-rays,
- laboratory tests,

- therapies,
- care from physicians who are specialists,
- hospital admissions, and
- follow-up care.

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. Also, if you need certain types of covered services or supplies, your PCP will need to get prior authorization (prior approval) from us. The following is a list of services and supplies for which prior authorization is required:

- inpatient hospital care;
- inpatient mental health care*;
- Skilled Nursing Facility care;
- Home Health care;
- outpatient mental health care and substance abuse services*,
- outpatient surgery services;
- ambulance services, **except in cases of emergency;**
- outpatient rehabilitation services (occupational/physical/speech and language therapy, cardiac rehabilitation services);
- certain types of durable medical equipment and prosthetic devices;
- certain outpatient diagnostic procedures, tests and lab services;
- certain outpatient diagnostic and therapeutic radiology services; and
- dialysis services received in the service area

***Special authorization rules apply to mental health care and substance abuse services. Please see the benefits chart in Section 10 for more information.**

Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 3 tells you how we will protect the privacy of your medical records and personal health information.

How do you choose a PCP?

When you complete your BlueMedicare HMO enrollment form, there is a section where you should indicate your selection of a PCP. **A PCP may be listed in your provider directory as a Family Practice, General Practice, Pediatrician or Internal Medicine physician**. If you do not choose a PCP on your enrollment form, one will be assigned to you. For assistance in choosing or changing your PCP, please call our toll-free Member Services number at 1-800-926-6565, 8:00 a.m. – 9:00 p.m. ET seven days a week. TTY users should call 711.

How do you get care from your PCP?

Because your PCP is responsible for coordinating your medical care and providing most of your routine health care needs, you will usually see him or her first when you need care.

How do you get care from physicians, specialists and hospitals?

A specialist is a physician who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such physicians as:

- oncologists (who care for patients with cancer)
- cardiologists (who care for patients with heart conditions),
- orthopedists (who care for patients with certain bone, joint, or muscle conditions).

You do not need a referral (approval in advance) from your PCP to see any plan specialists.

How can you switch to another PCP?

You may change your PCP for any reason. If we receive a request to change your PCP between the 1st and 10th of the month, the change will be effective the 1st of the following month. If we receive your request after the 10th of the month, the change will be effective the 1st of the second month following the current month. If you need care, continue to see your current PCP until the effective date of the change. To change your PCP, call Member Services at 1-800-926-6565, 8:00 a.m. – 9:00 p.m. ET seven days a week. TTY users should call 711. When you call, be sure to tell Member Services if you are getting covered services that needed your PCP's approval (such as Home Health services and durable medical equipment). Member Services will help make sure that you can continue with services you have been getting when you change to a new PCP. They will also check that the PCP you wish to switch to is accepting new patients. Member Services will tell you when the change to your new PCP will take effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What services can you get on your own, without getting approval in advance?

You may get the following services on your own, without approval in advance from your PCP (or the plan). You still have to pay your share of the cost, as appropriate, for these services.

- Services provided by plan specialists.
- Routine women's health care, which includes breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, provided you receive services from a network provider.
- Influenza and pneumonia vaccinations, as long as you get them from a plan provider.
- Emergency services, whether you get these services from plan providers or non-plan providers.
- Urgently needed care that you get from non-plan providers when you are temporarily outside the Plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get when you are temporarily outside the Plan's service area. If possible, however, please let us know before you leave the service area so we can help arrange your maintenance dialysis treatments while you are away from the service area.

If you need care when you are outside the service area, your coverage is limited. The only services we cover when you are outside our service area are care for a medical emergency, urgently needed care, renal dialysis and care that Health Options, Inc. or a plan provider has approved in advance. See below for more information about care for a medical emergency and urgently needed care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number listed in Section 8 of this booklet. Also see below for more information about how to fill your outpatient prescriptions when you travel or are away from the plan service area.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. Member Services can assist you in finding and selecting another provider.

Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. Contact your PCP and our Member Services Department at the phone numbers listed on the back of your membership card. Your PCP needs to know about your emergency because your PCP will provide follow-up care. **Please try to contact your PCP about your emergency within 48 hours.**

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out of network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States. We discuss filling prescriptions when you cannot access a network pharmacy later in this section.

- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information.)
- Please see Section 10 for information about coverage for medical emergencies (including related ambulance services) that occur while you are outside the United States.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'?" above. If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a network provider.** We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Inside the United States. (See Section 10 for information about the plan's coverage of urgently needed care outside the United States.)
- Temporarily absent from the Plan's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition**,** and
- It isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to Health Options, Inc., P. O. Box 1798, Jacksonville, Florida 32231-0014 so we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Member Services.

What is your cost for services that aren't covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. You can call Member Services when you want to know how much of your benefit limit you have already used.

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at **www.medicare.gov** under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in an RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan.

Medicare Inpatient Hospital coverage limits apply to care you receive in an RNHCI.

How you get prescription drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in Section 10.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is 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, generic drugs cost less than brand-name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our Website. You may also call Member Services to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or copayment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 5 to learn more about how to request an exception.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly (if there is a change). In addition, you may contact Member Services to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 5 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be

affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide you with the opportunity to request a formulary exception in advance for the following year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

If you are a member of our plan, an unexpected transition could occur if you experience a level-of-care change. For example, if you are hospitalized and given a drug that is not on our formulary, once you are discharged from the hospital to your home, you will need to talk to your doctor about continuing the drug. If you and your doctor decide you should continue taking the drug, you will need to request a formulary exception for us to cover it. However, our plan may provide you a temporary 30-day transition supply of the drug while you decide what action to take. Please contact us about the availability of a transition supply of medication when you experience a level-of-care change.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Section 10 for information about non-Part D drugs.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 18 pills per 31-day period for IMITREX (50 mg).

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Member Services. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 5 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies

- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost to members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a network pharmacy, there may be a difference in your cost-sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. You should keep the disclosure notices that you get each year in your personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs**

covered. A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Member Services.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Services to find another network pharmacy in your area.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call Member Services at 1-800-926-6565, 8:00 a.m. – 9:00 p.m. ET seven days a week, to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail-order pharmacy service?

When you order prescription drugs through our network mail-order pharmacy service, you must order at least a 31-day supply, and no more than a 90-day supply of the drug.

Generally, it takes the mail-order pharmacy 14 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. For drugs you need to start taking right away, ask your doctor for two prescriptions: one for a one-month supply to be filled at your local network retail pharmacy and one for a three-month supply, with the appropriate number of refills, to be filled by the mail-order pharmacy. This will allow time to process your mail-order prescription and for you to receive it through the mail.

You are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of maintenance medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of maintenance medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of maintenance medications. In this case, you will be responsible for the difference in price.

Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of maintenance medications. You can also call Member Services for more information.

To get order forms and information about filling your prescriptions by mail, please call PrimeMail® Pharmacy, our mail-order service provider, at 1-888-849-7845, 8:00 a.m. – 12:00 a.m. ET Monday - Friday and 8:30 a.m. - 9:00 p.m. ET Saturday - Sunday. TTY users should call 711. Or visit our web site at **www.bcbsfl.com**. Please note that you must use our network mail-order service. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just coinsurance or copayment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-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 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. In this situation, you will have to pay the full cost (rather than paying just your coinsurance or copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. 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. To learn how to submit a paper claim, please refer to the paper claims process described later. You can also call Member Services to find out if there is a network pharmacy in the area where you are traveling. If there are no network pharmacies in that area, Member Services may be able to make arrangements for you to get your prescriptions from an out-of-network pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside of the United States and territories, even for a medical emergency.

What if I need a prescription because of a medical emergency or because I needed 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. In this situation, you will have to pay the full cost (rather than paying just your coinsurance or copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. 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. To learn how to submit a paper claim, please refer to the paper claims process described later.

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, as well as some covered drugs that are administered in your doctor's office.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above (“How do you fill prescriptions outside the network?”), 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 and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs paid for in full when you don’t have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) because you don’t have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to

us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.
- **Drugs purchased at a better cash price**. In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.
- **Copayments for drugs provided under a drug manufacturer patient assistance program.** If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Member Services**. Please include your receipt(s) with your written request.**

Please send your written reimbursement request to the address listed under **Part D Reimbursement Requests** in Section 8.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, our Plan's medical (Part C) benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, our plan's Part D benefit will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they aren't covered by our medical benefit (Part C)). We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs aren't otherwise covered by our plan's medical benefit (Part C)). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Advantage Plan,

Prescription Drug Plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Member Services.

Home infusion pharmacies

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Member Services.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and aren't already covered by our Plan's medical benefit (Part C). This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheelchair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged 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 review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

Your right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing 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. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. 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, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in Section 5.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to 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 in 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 have an advance directive, you can get a 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. 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. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well.

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. If you are admitted to the hospital, they 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. If you have signed an advance directive, and you believe that a doctor or hospital hasn’t followed the instructions in it, you may file a complaint with the Florida Agency for Health Care Administration.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies and/or providers

You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

Your right to get information about your prescription drugs, Part C medical care or services, and costs

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Member Services for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit **www.medicare.gov** to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.

- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health or drug benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance or drug coverage. Call Member Services.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your coinsurance or copayment for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

4. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs, Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the Part C medical care or services or Part D drugs you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 5.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don't forward your case to the Independent Review Entity if we do not give you a decision on time.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person

legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) or **Part D Grievances** (for complaints about Part D drugs) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Formal Grievance Process**.

These requests must be submitted in writing. Please refer to the mailing address information for Part C and Part D grievances in Section 8. Requests for "fast" Part C grievances and for "standard" or "fast" Part D grievances may also be faxed to the numbers shown in Section 8.

While you are not required to use a Blue Cross and Blue Shield of Florida, Inc. (BCBSF) Grievance Form, we strongly urge you to submit your grievance on such a form. This form facilitates logging, identification, processing and tracking of the grievance through the formal review process. You may obtain forms by contacting Member Services at the number listed in Section 8.

Upon request, a Member Services Representative can assist you in preparing the grievance. If you are hearing or speech-impaired, contact Member Services by dialing the Florida Relay number listed in Section 8.

Both oral and written grievances will be investigated, and we will provide you with a decision within the timeframes shown in this section. You have the right to request a "fast" grievance if your request for a standard initial decision about medical care is delayed or if your request for a "fast" initial decision about care is delayed or denied. We must decide your "fast" grievance within 24 hours. Section 5 provides information about requesting a standard or "fast" initial decision about medical care and your rights to file a "fast" grievance.

In order to begin the formal review process, you must complete and send your BCBSF Grievance Form to the address shown in Section 8 or write a letter explaining the facts and circumstances relating to the grievance. You should provide as much detail as possible and attach copies of any relevant documentation, including medical records. The BCBSF Grievances & Appeals Department will review the grievance in accordance with the standard grievance process and advise you of the decision in writing.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part D Prescription Drug(s) and/or Part C Medical Care and Service(s)

Introduction

This section explains how you ask for coverage of your Part D drug(s) and Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs and/or Part C medical care or services. For more information about grievances, see Section 4.

Part 1. Requests for Part D drugs and Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for Part D drugs and/or medical care or services or payment

This part explains what you can do if you have problems getting the Part D drugs and/or Part C medical care or service you request, or payment (including the amount you paid) for a Part D drug and/or Part C medical care or service you already received.

If you have problems getting the Part D drugs and/or Part C medical care or services you need, or payment for a Part D drug and/or Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug and/or Part C medical care or service you need, or paying for a Part D drug and/or Part C medical care or service you already received. Initial decisions about Part D drugs are called "**coverage determinations**." Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part D drug and/or Part C medical care or service you are requesting, or pay for the Part D drug and/or Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. **See "What is an exception?" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances.
- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 2 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs.
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our Covered Brand tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the Covered Preferred Brand tier instead. This would lower the copayment amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for Part D drugs that are in the Covered Specialty tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary or the Part D drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the copayment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under **Part D Coverage Determinations** in Section 8 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under "**Part D Coverage Determinations**" in Section 8. To learn how to name your appointed representative, you may call Member Services.

You also have the right to have a lawyer act for you. 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.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part D drug and/or Part C medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug and/or Part C medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8. If you call outside of regular weekday business hours, you will have to leave a message.
Be sure to include the following information in your message:

- Your name;
- Your phone number, including your area code;
- Your ID number listed on your membership card;
- The name and telephone number of the physician who prescribed your drug or provided your care or services; and
- The reason you need a coverage determination or an organization determination and what problem or issue you have with your prescription drug or your medical care or services.

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part D drug and/or Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

If you call after regular weekday business hours, you will have to leave a message. Be sure to include the following information in your message:

- Your name;
- Your phone number, including your area code;
- Your ID number listed on your membership card;
- The name and telephone number of the physician who provided your care or service or prescribed your drug; and
- The reason you are requesting a fast decision.

Be sure to ask for a "fast," or "expedited" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as prior authorization, quantity limits, or step therapy requirements), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

  If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received.

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

  If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

  If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Part C medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. For more information about fast grievances, see Section 4.

If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received.

  If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

  If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 4.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

- For a decision about payment for Part C medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received. We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "**redetermination**." An appeal to the plan about Part C medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug and/or Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about medical care or services) in Section 8.

You may also ask for a standard appeal by calling us at the phone number shown under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D drug and/or Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

To deliver requests that are made outside of regular weekday business hours, please fax information to the fax number listed under **Part D Appeals (**for appeals about Part D drugs) or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination and organization determination level, the place where the appeal is sent is different; please send appeal requests to the addresses listed under Part D Appeals (for appeals about Part D drugs) and Part C Appeals (for appeals about Part C medical care or services) in Section 8 of this booklet.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 72 hours after we receive your request.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services.

  We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug and/or Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the IRE's

decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the "Important Message from Medicare" (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at **http://www.cms.hhs.gov/BNI**). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the "Important Message from Medicare" to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the "Important Message from Medicare" more than 2 days before your discharge day, it must give you a copy of your signed "Important Message from Medicare" before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. In Florida, the QIO is called FMQAI. The doctors and other health experts in FMQAI review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting FMQAI to review your hospital discharge

You must quickly contact FMQAI. The "Important Message from Medicare" gives the name and telephone number of FMQAI and tells you what you must do.

- You must ask FMQAI for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from FMQAI no later than the day you are scheduled to be discharged from the hospital. **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 FMQAI.**
- FMQAI will look at your medical information provided to FMQAI by us and the hospital.
- During this process you will get a notice, called the "Detailed Notice of Discharge," giving the reasons why we believe that your discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227) - TTY users should call 1-877-486-2048 to get a sample notice or see it online at **http://www.cms.hhs.gov/BNI/**.
- FMQAI will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if FMQAI decides in your favor?

We will continue to cover your hospital stay (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if FMQAI agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after FMQAI gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after FMQAI gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask FMQAI to review its first decision if you make the request within 60 days of receiving FMQAI's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after FMQAI gave you its first decision.

What happens if you appeal FMQAI's decision?

FMQAI has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If FMQAI agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the "Important Message from Medicare," and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If FMQAI upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision

makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask FMQAI for a review by the deadline?

If you do not ask FMQAI for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the "Notice of Medicare Non-Coverage" at least 2 days before coverage for your services ends (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at **http://www.cms.hhs.gov/BNI/**). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting QIO (FMQAI) review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the "QIO," which in Florida is called FMQAI) to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for FMQAI's review?

You must quickly contact FMQAI. The written notice you got from your provider gives the name and telephone number of FMQAI and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact FMQAI no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during FMQAI's review?

FMQAI will ask 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. FMQAI will also look at your medical information, talk to your doctor, and review information that we have given to FMQAI. During this process, you will get a notice called the "Detailed Explanation of Non-Coverage" giving the reasons why we believe coverage for your services should end. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at **http://www.cms.hhs.gov/BNI/**. FMQAI will make a decision within one full day after it receives all the information it needs.

What happens if FMQAI decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if FMQAI agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask FMQAI to review its first decision if you make the request within 60 days of receiving FMQAI's first denial of your request.

What happens if you appeal FMQAI's decision?

FMQAI has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If FMQAI agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If FMQAI upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask FMQAI for a review by the deadline?

If you do not ask FMQAI for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

6. Ending your Membership

Ending your membership in our Plan 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.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan**: Simply join the new plan. You will be disenrolled from our plan when your new plan's coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan and joining a Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.
- **If you are planning on switching to the Original Medicare Plan without a Medicare Prescription drug plan:** Contact Member Services for information on how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1

Enrollment Period	When?	Effective Date
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request
Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the *"Medicare & You"* handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from **www.medicare.gov** - under "Search Tools," select "Find a Medicare Publication."

Until your membership ends, you must keep getting your Medicare services and/or prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care and prescription drugs as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy, including our mail-order pharmacy service, are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your prescription drug plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B.
- If you move out of the service area or are away from the service area for more than 6 months, you cannot remain a member of our Plan. And we must end your membership ("disenroll" you). If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.

- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

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 will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Agreement – This Evidence of Coverage, any attachments, endorsements and/or amendments that may be added in the future.

Ambulatory Surgical Center – A facility that meets Original Medicare's conditions of participation is properly licensed pursuant to the State's applicable laws and whose primary purpose is to provide elective surgical care to a patient admitted to and discharged from such facility within the same working day, and which is not part of a Hospital.

Annual Coordinated Election Period (also known as Annual Election Period) – The annual election period is conducted between November 15 and December 31 each year. Each year, organizations offering Medicare Advantage (MA) plans in January of the following year must open enrollment to Medicare beneficiaries. During the annual election period, an individual eligible to enroll in an MA plan may change his or her election from an MA plan to Original Medicare or to a different MA plan, or from Original Medicare to an MA plan.

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services and/or prescription drugs or payment for services and/or prescription drugs you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug/item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit Period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Bone Marrow Transplant – Human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy. Human blood precursor cells may be obtained from the patient in an autologous transplant or an allogeneic transplant from a medically acceptable related or unrelated donor, and may be derived from bone marrow, the circulating blood, or a combination of bone marrow and circulating blood. If chemotherapy is an integral part of the treatment involving bone marrow transplantation, the term "bone marrow transplant" includes the transplantation, the administration of chemotherapy and the chemotherapy drugs. The term "bone marrow transplant" also includes any services or supplies relating to any treatment or therapy involving the use of high dose or intensive dose chemotherapy and human blood precursor cells, and includes any and all hospital, physician or other health care provider services or supplies which are rendered in order to treat the effects of,

or complications arising from, the use of high dose or intensive dose chemotherapy or human blood precursor cells (e.g., hospital room and board and ancillary services).

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.

Calendar Year – A 12-month period that begins on January 1 and ends 12 consecutive months later on December 31.

Catastrophic Coverage – The phase in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,350 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Coinsurance – A payment you make for your share of the cost of certain covered services or prescription drugs you receive. Coinsurance is a percentage of the cost of the service or prescription drug. You pay your coinsurance when you get the service or prescription drug.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility designed to permit the Member to receive multidisciplinary rehabilitation services at a single location in a coordinated fashion.

Condition – A disease, illness, ailment, injury, bodily malfunction, or pregnancy of a Member.

Convenient Care Center – A walk-in healthcare clinic that specializes in the treatment of common illnesses and provides basic health screening services.

Copayment – The dollar amount established solely by HOI that is required to be paid to a Provider by a Member at the time certain covered services or prescription drugs are rendered by that Provider. This amount may vary depending on, among other things, the contracting status of the Provider rendering the service or providing the drug and the type of service being rendered or the drug received. In no event will such amount exceed the amount specified in the Schedule of Benefits as the copayment for the service or drug.

Except as otherwise established solely by HOI, if more than one Covered Service is rendered by a Provider during a single office visit, the Copayment shall not exceed the highest Copayment specified in the Schedule of Benefits and Copayment for any of the services rendered during such office visit, regardless of the number of services rendered during such office visit.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when drugs/services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs/services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs/services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug/service.

County – A local administrative subdivision of a State, as defined by the State.

Coverage Determination – A decision from your Medicare drug plan 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 if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Covered Services – The general 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 – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial Care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Effective Date – The date, as shown in HOI's enrollment records and on your plan membership card, on which coverage begins for you under this Agreement. You will receive written notification of your effective date once HOI has submitted and confirmed your enrollment with CMS.

Election Form(s) – The HOI form(s) that are used to maintain accurate enrollment files. Such form(s) include: The Member Enrollment Form and the Disenrollment Form.

e-Medicine – A secure, web-based communication tool that links patients with their providers that have enrolled in the program. Members can schedule appointments; request prescription drug refills, referrals and lab results; and even receive non-urgent online care through use of the confidential web visit.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to 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 or riders, 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 determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the Plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

Exclusion – Benefits, services or supplies that are not covered under this Agreement. You are responsible for paying for excluded items or services.

Experimental or Investigational – Services and supplies, including drugs or devices, determined by Original Medicare not to be generally accepted by the medical community. When making a determination as to whether a service is experimental or investigational, HOI will use Original Medicare guidelines or rely upon determinations already made by Original Medicare. Experimental or Investigational services are not covered.

Formulary – A list of covered drugs provided by the Plan.

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, generic drugs cost less than brand-name drugs.

Grievance – A type of complaint you make about us or one of our network providers/pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Health Care Service or Services – Includes treatments, therapies, devices, procedures, techniques, equipment, supplies, products, remedies, vaccines, biological products, drugs, pharmaceuticals, chemical compounds, and other services rendered or supplied by, or at the direction of, Providers.

HMO – Health Maintenance Organization.

Home Health Agency – An Original Medicare certified agency, which provides intermittent skilled nursing services, and other therapeutic services in your home when medically necessary, when you are confined to your home, and when authorized by your plan physician.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit **www.medicare.gov** and under "Search Tools" choose "Find a Medicare Publication" to view or

download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Hospital – A Medicare-certified institution:

- Which is licensed by a State; is accredited as a Hospital under the Hospital Accreditation Program of the Joint Commission on Accreditation of Healthcare Organizations, American Osteopathic Association, or other accrediting organizations acceptable to HOI; and meets Original Medicare's conditions of participation; and
- Which is operated pursuant to law, under the supervision of a staff of physicians with 24-hour-a-day nursing service, and which is primarily engaged in providing:
  - general inpatient medical care and treatment of sick or injured persons through medical, diagnostic and major surgical facilities on the premises or under its control; or
  - specialized inpatient medical care and treatment of sick or injured persons through medical or diagnostic facilities (including x-ray and laboratory) on its premises and under its control, or through a written agreement with a Hospital (as defined above) or specialized provider of those facilities; and
- The term Hospital does not include: an Ambulatory Surgical Center; a Skilled Nursing Facility (SNF); a stand-alone Birth Center; a facility for diagnosis, care and treatment of Mental and Nervous Disorders or alcoholism and drug dependency; a convalescent, rest or nursing home; or a facility which primarily provides Custodial, educational or rehabilitative care.

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

Initial Coverage Period – This is the period before your total drug expenses have reached $2,700, including amounts you've paid and what our Plan has paid on your behalf.

Inpatient Care – Health care that you get when you are admitted to a hospital.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medicaid – A joint Federal/State medical assistance program established by Title XIX of the Social Security Act. Some Original Medicare beneficiaries are also eligible for Medicaid. Medicaid, unlike Original Medicare, can cover long-term care, such as custodial nursing home care. Medicaid can cover all or part of your monthly plan premium if your income and resources are low enough. You should inquire about Medicaid and related programs at your local Department of Social Services.

Medically Necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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 (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 (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plans in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. 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**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Part A Premium – Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the Self-Employment Tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state or local government employment to be insured, you do not have to pay a monthly premium. If you do not qualify for premium-free Medicare Part A benefits, you may buy the coverage from the Social Security Administration (SSA) if you are at least 65 years old and meet certain requirements. You may also buy Medicare Part A from SSA if you are under age 65 and are entitled to Original Medicare under the disability provisions.

Medicare Part B – A voluntary program that covers the cost of Physicians' services and certain other services that are not covered under Medicare Part A. It is funded through a monthly premium for Medicare Part B from participating Medicare beneficiaries and contributions from the Federal Government.

Medicare Part B Premium – Your Medicare Part B premium paid to Original Medicare, usually a deduction from your Social Security check, which entitles you, the Member, to the Medicare Part B benefits. (You must continue to pay this premium to Original Medicare to receive covered services.)

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.

"Medigap" (Medicare supplement insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

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

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

Membership Cards – The cards that are issued to you by HOI to show that you have chosen to enroll as a Member of our MA HMO Plan and that you have Part D prescription drug benefits as part of that plan. Use only your Medicare Advantage HMO ID card for your health care services and use only your Part D Prescription Drug Plan ID card for your prescription drugs.

Mental and Nervous Disorder – Any and all disorders set forth in the diagnostic categories of the most recently published edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, regardless of the underlying cause or effect of the disorder.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. 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 we use 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. We call them "**network providers**" when they 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. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Non-plan Provider or Non-Plan Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Non-plan providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. As explained in this booklet, most services you get from non-plan providers are not covered by our Plan or Original Medicare.

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to 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 Provider or Out-of-Network Facility – A provider or facility with which we have not arranged 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 or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of

Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see "Medicare Advantage (MA) Plan"

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 2 tells more about PCPs.

Prior Authorization – Approval in advance to get services and/or certain drugs that may or may not be on our formulary. In an HMO, some in-network services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in Section 10.

Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

Quantity Limits – A utilization 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.

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

Respite Care – Care that provides relief to a primary caregiver who is maintaining and supporting a chronically dependent individual in their home, but who, for a variety of reasons, is temporarily unable to perform that role.

Service Area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled Nursing Facility (SNF) Care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment,

such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Special Election Period (SEP) – Special periods of time in which an enrollee can enroll in or disenroll from an Medicare Advantage (MA) or Part D Plan and change his/her enrollment to another Plan, or return to Original Medicare. A Special Election Period is warranted for circumstances including, but not limited to, such as: the MA or Part D Plan in which the Member is enrolled is terminated; the enrollee permanently moves out of (or temporarily leaves for over 6 months) the service area of the MA or Part D Plan; the Medicare Advantage Organization or Medicare Part D Sponsor offering the plan violated a material provision of its contract with the enrollee; or the enrollee meets such other conditions as CMS may provide.

Specialist – A Physician who is a Contracted Plan Provider, or a Physician who is a Non-Contracted Provider when authorized by HOI, who limits practice to specific services or procedures (e.g., surgery, radiology, pathology), certain age categories of patients (e.g., pediatrics, geriatrics), certain body systems (e.g., dermatology, orthopedics, cardiology) or types of diseases (e.g., allergy, psychiatry, infectious diseases, oncology). Specialists may have special education and training related to their respective practice and may or may not be certified by a related specialty board.

Step Therapy – A utilization management 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 the Social Security Administration 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.

Termination Date – The date your plan membership ends.

Urgently Needed Care – Section 2 explains about "urgently needed" services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL	**1-800-926-6565**. Calls to this number are free. Our Plan Member Services is open from 8:00 a.m. – 9:00 p.m. ET, seven days a week, all year long. You will be able to speak to a Member Services Representative during these hours no matter what time of the year you need assistance.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	**1-800-706-5236**
WRITE OR VISIT	HOI Member Services 8400 NW 33rd Street Suite 100 Miami, FL 33122-1932
WEBSITE	**www.bcbsfl.com**

Contact Information for Grievances, Organization Determinations, Coverage Determinations and Appeals

Part C Organization Determinations (about your Medical Care and Services)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	For a "fast" decision about medical care (rather than a "standard" decision), you may fax requests to **1-305-716-9333**.
WRITE	HOI Utilization Management Department 8400 NW 33rd Street Suite 100 Miami, FL 33122-1932

For information about Part C organization determinations, see Section 5.

Part C Grievances (about your Medical Care and Services)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	You may fax requests for "fast" grievances to **1-305-716-9333**.
WRITE	HOI Grievances and Appeals Department 8400 NW 33rd Street Suite 100 Miami, FL 33122-1932

For information about Part C grievances, see Section 4.

Part C Appeals (about your Medical Care and Services)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	**1-305-437-7490**
WRITE	HOI Grievances and Appeals Department 8400 NW 33rd Street Suite 100 Miami, FL 33122-1932

For information about Part C appeals, see Section 5.

Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	**1-800-693-6703**
WRITE	Prime Therapeutics LLC Attention: Medicare Coverage Determinations Department 1305 Corporate Center Drive, Bldg. EC Eagan, MN 55121

For information about Part D coverage determinations, see Section 5.

Part D Reimbursement Requests (about your Part D prescription drugs)

CALL	**1-800-926-6565.** Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
WRITE	BlueMedicare P.O. Box 64813 St. Paul, MN 55164

Part D Grievances (about your Part D Prescription Drugs)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	**1-888-285-2242**
WRITE	Prime Therapeutics LLC Attention: Medicare Grievance Dept. 1305 Corporate Center Drive, Bldg. EC Eagan, MN 55121

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D Prescription Drugs)

CALL	**1-800-926-6565**. Calls to this number are free.
TTY/TDD	**711**. This number requires special telephone equipment. Calls to this number are free.
FAX	**1-800-693-6703**
WRITE	Prime Therapeutics, LLC Attention: Medicare Appeals Department 1305 Corporate Center Drive, Bldg. EC Eagan, MN 55121

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit **www.medicare.gov** and choose "Find Helpful Phone Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Serving Health Insurance Needs of Elders (SHINE)

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. SHINE can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. SHINE has information about Medicare Advantage Plans, Medicare Prescription Drug Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact SHINE at SHINE Program, Department of Elder Affairs, 4040 Esplanade Way, Suite 270, Tallahassee, FL 32399-7000. The telephone number is 1-800-963-5337. You may also find the website for SHINE at **www.medicare.gov** under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

FMQAI

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact FMQAI at FMQAI, 5201 W. Kennedy Boulevard, Suite 900, Tampa, FL 33609-1822, or call 1-800-844-0795.

How to contact the Medicare program

Medicare is 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). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.

- Visit **www.medicare.gov** for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." 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.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Florida's Agency for Health Care Administration, 2727 Mahan Drive, Tallahassee, FL 32308. The telephone number is 1-888-419-3456.

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit **www.rrb.gov** on the Web.

Employer (or "Group") Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. **Important Note:** Your (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this 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.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. 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, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Subrogation

As part of this Agreement, Health Options, Inc. (HOI) retains its right to collect from any third party, amounts paid for benefits for you under this Agreement that the third party is obligated to pay. This right is HOI's Subrogation right. In the event any payments, services or supplies are rendered to or on behalf of a Member, HOI, to the extent of any such payment, or services or supplies rendered, shall be subrogated to all causes of action and rights of recovery such Member may have or has against any persons and/or organizations as a result of such payment, or services or supplies rendered. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated. The Member shall promptly execute and deliver such instruments and papers with respect to such subrogation rights as may be requested by HOI. Further, the Member shall promptly notify HOI of any settlement negotiations prior to entering into a settlement agreement affecting any subrogation rights of HOI. Additionally, in no event shall a Member fail to take any action where action is appropriate, or take any action that may prejudice the subrogation rights of HOI. No waiver, release of liability, settlement, or other documents executed by a Member without prior notice to and approval by HOI shall be binding upon HOI. In any event, HOI retains the right to recover such payments and/or the reasonable value of the covered services provided from any person or organization to the fullest extent permitted by law. With respect to covered services provided, HOI shall be entitled to reimbursement for the reasonable value of such covered services as determined on a fee-for-service basis.

Notice about HOI and the Blue Cross and Blue Shield Association

You as a member of this plan hereby expressly acknowledge your understanding that this plan constitutes a contract solely between you and HOI, a subsidiary of Blue Cross and Blue Shield of Florida, Inc., which is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting HOI to use the Blue Cross and Blue Shield Service Marks in the State of Florida, and that HOI is not contracting as the agent of the Association. You further acknowledge and agree that you have not entered into this Plan based upon representations by any person other than HOI and that no person, entity, or organization other than HOI shall be held accountable or liable to you for any of HOI's obligations to you created under this Plan. This paragraph shall not create any additional obligations whatsoever on the part of HOI other than those obligations created under other provisions of this agreement.

10. How Much You Pay for Your Part C Medical Benefits and/or Part D Prescription Drugs

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under "General Exclusions" you can find information about services that are not covered. It also tells about limitations on certain services. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section.

What do you pay for covered services?

Copayments and coinsurance are the amounts you pay for covered services.

- A **"copayment"** is a payment you make for your share of the cost of certain covered services you get. A copayment is a set amount per service. You pay it when you get the service.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Benefits Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Benefits Chart in bold.

See Section 2 for information on requirements for using network providers.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient Services	
Inpatient hospital care You are covered for unlimited days of medically necessary care. Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Physician Services	**Days 1-5:** $200 copayment per day (per benefit period) **After the 5th day, the plan pays 100% of covered expenses, per benefit period.** If you get authorized inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital. A benefit period begins the day you go into a hospital. The benefit period ends when you have not received hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Prior authorization is required for inpatient hospital care (except for emergency and urgently needed care).** Hospitals can submit requests directly to receive authorization.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. • Covered services in a psychiatric hospital are subject to a 190-day lifetime limit. • The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	**Days 1-5:** $200 copayment per day (per benefit period) **After the 5th day, the plan pays 100% of covered expenses, per benefit period.** A benefit period begins the day you go into a hospital. The benefit period ends when you have not received hospital care for 60 days in a row. If you go into a hospital after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. **Prior authorization is required for inpatient mental health care (except for emergency and urgently needed care).** Hospitals can submit requests directly to receive authorization. All inpatient mental health services are coordinated through an external vendor. Call 1-800-835-2094 or contact Member Services for more information.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Skilled nursing facility (SNF) care Coverage is limited to 100 days per benefit period. No prior hospital stay is required. Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	**Days 1-6:** $0 copayment per day (per benefit period) **Days 7-25:** $75 copayment per day (per benefit period) **Days 26-100:** $0 copayment per day (per benefit period) A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you have not received skilled nursing facility care for 60 days in a row. If you go into 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 you can have. **Prior authorization is required for skilled nursing facility care (except for emergency and urgently needed care).** Skilled nursing facilities can submit requests directly to receive authorization.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include: • Physician services • Tests (like X-ray or lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetic and Orthotic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	For physician's services and for physical therapy, speech therapy and occupational therapy, you pay the following copayments: • $10 copayment per visit when services are provided by a Primary Care Physician • $25 copayment per visit when services are provided by a Specialist For all other covered services, you pay $0 copayment.
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies • Up to 80 hours of respite care annually when all guidelines are met	• $0 copayment for Medicare-covered home health visits (including home infusion services) and respite care. **Prior authorization is required for home health care (including home infusion therapy).** Home health agencies can submit requests directly to receive authorization.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan. • $0 copayment for hospice consultation services
Outpatient Services	
Physician services, including doctor office visits Covered services include: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center • Consultation, diagnosis, and treatment by a specialist • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another network provider prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor) • Convenient Care Center visits • e-Medicine visits	Office Visits • $10 copayment for PCP visits • $25 copayment for specialist visits Convenient Care Center Visits • $10 copayment per visit e-Medicine Visits • $5 copayment per visit Medicare-Covered Dental and Hearing Services • $25 copayment per visit Outpatient Hospital and Ambulatory Surgical Center Services • $0 copayment for physician services (facility copayment may apply)

Benefits chart – your covered services	**What you must pay** when you get these covered services
Allergy injections	• $5 copayment per visit
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	• $10 copayment when services are provided by a PCP • $25 copayment when services are provided by a specialist
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. • Other routine foot care (up to six visits per year).	• $25 copayment for podiatry services when services are provided by a podiatrist
Outpatient mental health care (including Partial Hospitalization Services) Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	• $25 copayment for each individual or group therapy visit • $0 copayment for Partial Hospitalization Services **Prior authorization is required for outpatient mental health care services.** For Partial Hospitalization Services, hospitals and facilities can submit requests directly to receive authorization. All mental health services are coordinated through an external vendor. Call 1-800-835-2094 or contact Member Services for more information.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient substance abuse services	• $25 copayment for individual or group visits **Prior authorization is required for outpatient substance abuse services.** Member can submit request directly to receive authorization. All mental health services are coordinated through an external vendor. Call 1-800-835-2094 or contact Member Services for more information.
Outpatient surgery (including services provided at ambulatory surgical centers)	• $75 copayment for each Medicare-covered ambulatory surgical center visit for outpatient surgery • $125 copayment for each Medicare-covered outpatient hospital facility visit for surgery **Prior authorization is required for outpatient surgery.** Hospital/facility can submit request directly to receive authorization.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	• $100 copayment for each Medicare-covered trip (one-way) **Except for emergency care, prior authorization is required for ambulance services.**

Benefits chart – your covered services	**What you must pay** when you get these covered services
Emergency care BlueMedicare HMO provides worldwide emergency coverage.	In- and Out-of-Network • $50 copayment for emergency room visits. This copayment is waived if you are immediately admitted to the hospital. If you receive emergency services outside the United States and its territories, you may have to pay 100% of the charges at the time services are provided. You may then submit a claim to the plan for reimbursement of your expenses (not including plan copayments). If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, you must return to a plan-contracting hospital in order for your care to continue to be covered, or you must have your inpatient care at the non-plan hospital authorized by the plan and your cost is the cost-sharing you would pay at a plan hospital.
Urgently needed care BlueMedicare HMO provides worldwide coverage of urgently needed care.	In- and Out-of-Network • $10 copayment when services provided in a PCP's office • $25 copayment when services provided in a specialist's office • $25 copayment when services provided at an Urgent Care Center If you receive urgently needed care outside the United States and its territories, you may have to pay 100% of the charges at the time services are provided. You may then submit a claim to the plan for reimbursement of your expenses (not including plan copayments).

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	• $10 copayment if services provided in a PCP's office • $25 copayment if services provided in the following places of service: - Specialist's office - Free-standing rehabilitation facility - Outpatient hospital facility **Prior authorization is required for outpatient rehabilitation services.** Facility/therapy center can submit requests directly to receive authorization. An authorization is given for 60 days starting with the first day of therapy (not the assessment) if clinical criteria are met. Following the 60 days, the authorization may be extended based on clinical criteria and continued improvement.
Durable medical equipment and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 7.)	• $0 copayment for all durable medical equipment except motorized wheelchairs and electric scooters • $500 copayment for motorized wheelchairs and electric scooters **Prior authorization is required for certain types of durable medical equipment.**

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prosthetic devices and related supplies – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	• $0 copayment for Medicare-covered devices and supplies **Prior authorization is required for certain items.**
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests as ordered by your physician.	• $0 copayment for the following: - Diabetes self-monitoring training - Diabetes supplies - Glucose tests An office or facility copayment will apply depending on the place of service: <u>Physician's Office</u> • $10 PCP copayment or • $25 specialist copayment <u>Outpatient Facility</u> • $125 hospital copayment (except for glucose tests) • $15 copayment for glucose tests in an outpatient hospital facility
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	• $0 copayment
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood – Coverage of blood, storage and	• $0 copayment for allergy testing • $0 copayment for lab services provided at an Independent Clinical Laboratory (ICL) • $10 copayment when diagnostic tests provided by a PCP, <u>except for Advanced Imaging Services</u>

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies (continued) administration begins with the first pint of blood that you need. • Other outpatient diagnostic tests, including **Advanced Imaging Services** (e.g., Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Positron Emission Tomography (PET), Computer Tomography (CT) scan or Nuclear Medicine Testing).	• $15 copayment for **lab services only** when provided in an outpatient hospital facility • $25 copayment when diagnostic tests provided by a specialist, <u>except for Advanced Imaging Services</u> • $75 copayment when diagnostic tests are performed in an Independent Diagnostic Testing Facility (IDTF), <u>except for Advanced Imaging Services</u> • **$100 copayment for Advanced Imaging Services However, if Advanced Imaging Services are provided in an outpatient hospital facility, they will be subject to the outpatient hospital copayment.** • **$125 copayment when diagnostic tests, including Advanced Imaging Services, are provided in an outpatient hospital facility (See exception above for lab services.)** • $25 copayment when radiation therapy is provided in a specialist's office • $50 copayment when radiation therapy is provided in an outpatient hospital facility **Prior authorization may be required for certain services. Please call Member Services for additional information.**

Benefits chart – your covered services	**What you must pay** when you get these covered services
Vision care Covered services include: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	Plan coverage is limited to services and supplies covered by Medicare. • $25 copayment for physician services to diagnose and treat diseases and conditions of the eye. • $0 copayment for one pair of eyeglasses or contact lenses after each cataract surgery. - Basic frames will be covered up to the Medicare fee schedule amount. - Basic lenses will be covered in full based on the prescription. Additional items (e.g., anti-glare or transitional coatings) will not be covered.
Preventive Care and Screening Tests	
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	• $0 copayment for Medicare-covered screening An office or facility copayment will apply depending on the place of service: <u>Physician's Office</u> • $25 copayment if services are provided in a specialist's office <u>Outpatient Facility</u> • $75 Independent Diagnostic Testing Facility (IDTF) copayment or • $125 hospital copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	• $0 copayment for Medicare-covered bone-mass measurements An office or facility copayment will apply depending on the place of service: Physician's Office • $10 PCP copayment or • $25 specialist copayment Outpatient Facility • $75 Independent Diagnostic Testing Facility copayment or • $125 hospital copayment
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy There is no limit to the number of covered colorectal screenings you may have in addition to the Medicare-covered screenings listed above.	• $0 copayment for colorectal screening An office or facility copayment will apply depending on the place of service: Physician's Office • $10 PCP copayment or • $25 specialist copayment Outpatient Facility • $125 hospital copayment
Immunizations Covered services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk We also cover some vaccines under our outpatient prescription drug benefit.	• $0 copayment for immunizations. An office visit copayment will apply if this is the only service provided: • $10 PCP copayment or • $25 specialist copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older There is no limit to the number of covered mammography screenings you may have in addition to the Medicare-covered screenings listed above.	• $0 copayment at any place of service
Pap tests, pelvic exams, and clinical breast exams Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months There is no limit to the number of covered pap tests and pelvic exams you may have in addition to the Medicare-covered services listed above.	• $0 copayment for pap tests, pelvic exams and clinical breast exams An office visit copayment will apply if these are the only services provided: • $10 PCP copayment or • $25 specialist copayment
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test There is no limit to the number of covered prostate cancer screenings you may have in addition to the Medicare-covered services listed above.	• $0 copayment for prostate cancer screening exams An office visit copayment will apply if this is the only service provided: • $10 PCP copayment or • $25 specialist copayment
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Routine cardiovascular disease testing is covered every year as part of a routine physical exam.	• $0 copayment for cardiovascular disease testing An office visit copayment will apply if a physical exam is the only service provided: • $10 PCP copayment or • $25 specialist copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Physical exams You are covered for one routine physical exam per year. Covered services include, but aren't limited to, the following: • Checking your height, weight, temperature, blood pressure and pulse. • Stethoscopic exam of your heart and lungs. • Review of your medical history. • Reflex testing. • Routine urinalysis. • Blood tests, including determination of glucose and cholesterol levels.	• $0 copayment for physical exams. An office visit copayment will apply if this is the only service provided: • $10 PCP copayment or • $25 specialist copayment
Other Services	
Dialysis (Kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	• $15 copayment for dialysis Coverage of out-of-area dialysis services is limited to the Medicare-allowable. **Prior authorization is required for dialysis.**
Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if	• 20% of the cost of drugs covered under Part B, **including chemotherapy drugs** In addition, an office or facility copayment will apply depending on the place of service: <u>Physician's Office</u> • $10 PCP copayment or • $25 specialist copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Medicare Part B Prescription Drugs (continued) you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases Section 2 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.	Outpatient Facility • $125 outpatient hospital copayment unless Part B drugs and radiation therapy are provided during the same visit. • $50 outpatient hospital copayment if radiation therapy and Part B drugs are provided during the same visit.
Additional Benefits	
Dental Services Services must normally be provided by **plan general dentists.** Please contact Member Services for information about any specialist or emergency care you may need.	
Service Code and Description	
Diagnostic	
00120 - Periodic oral evaluation (1 every 6 months)	$0 copayment
00150 - Comprehensive oral evaluation (1 every 24 months)	$0 copayment
00210 - Full mouth series x-rays (1 every 36 months)	$0 copayment
00272 - Bitewing X-rays (2) (1 every 12 months)	$0 copayment
00330 - Panoramic film (1 every 36 months)	$0 copayment
01110 - Adult Cleaning (1 every 6 months)	$0 copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Diagnostic - continued	
01203 - Application of fluoride (1 every 12 months, to age 16)	$0 copayment
Restorative (Fillings)	
02140 - Amalgam, one surface (1 tooth per 24 months)	$30 copayment
02150 - Amalgam, two surfaces (1 tooth per 24 months)	$35 copayment
02160 - Amalgam, three surfaces (1 tooth per 24 months)	$45 copayment
02330 - Resin restoration one surface, anterior (1 tooth per 24 months)	$45 copayment
02331 - Resin restoration two surfaces, anterior (1 tooth per 24 months)	$50 copayment
02332 - Resin restoration three surfaces, anterior (1 tooth per 24 months)	$60 copayment
02391 - Resin-based composite - one surface, posterior (1 tooth per 24 months)	$40 copayment
02392 - Resin-based composite - two surfaces, posterior (1 tooth per 24 months)	$50 copayment
02393 - Resin-based composite - three surfaces, posterior (1 tooth per 24 months)	$60 copayment
Restorative (Crowns)	
02750 - Porcelain high noble crown (1 tooth per 5 years)	$350 copayment
02751 - Porcelain base metal crown (1 tooth per 5 years)	$350 copayment
02752 - Porcelain noble metal crown (1 tooth per 5 years)	$350 copayment
02790 - Full cast high noble crown (1 tooth per 5 years)	$350 copayment
02791 - Full cast base metal crown (1 tooth per 5 years)	$350 copayment
02792 - Full cast noble metal crown (1 tooth per 5 years)	$350 copayment
02950 - Core build-up, including any pins (1 tooth per 5 years)	$112 copayment
02952 - Cast post and core in addition to crown (1 tooth per 5 years)	$170 copayment
Endodontics (Root Canal)	
03310 - Anterior root canal	$200 copayment
03320 - Bicuspid root canal	$200 copayment
03330 - Molar root canal	$200 copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Periodontics (Gum Treatment)	
04210 - Gingivectomy, per quadrant (1 per 24 months)	$230 copayment
04260 - Osseous surgery, per quadrant (1 per 24 months)	$275 copayment
04341 - Periodontal scaling and root planing, per quadrant (1 per 24 months)	$100 copayment
04355 - Full mouth debridement (1 per 24 months)	$75 copayment
04910 - Periodontal maintenance (1 per 6 months)	$35 copayment
Prosthodontics (Removable)	
05110 - Complete upper denture (1 per 5 years)	$465 copayment
05120 - Complete lower denture (1 per 5 years)	$465 copayment
05130 - Immediate upper denture (1 per 5 years)	$465 copayment
05140 - Immediate lower denture (1 per 5 years)	$465 copayment
05213 - Lower partial denture (1 per 5 years)	$320 copayment
05214 - Upper partial denture (1 per 5 years)	$320 copayment
05730 / 31 - Reline upper or lower denture (chair side) (1 per 24 months)	$90 copayment
05740 / 41 - Reline upper or lower partial denture (chair side) (1 per 24 months)	$85 copayment
05750 / 51 - Reline upper or lower denture (laboratory) (1 per 24 months)	$140 copayment
05760 / 61 - Reline upper or lower partial denture (laboratory) (1 per 24 months)	$140 copayment
Prosthodontics (Fixed)	
06210 - Pontic, cast high noble metal (1 tooth per 5 years)	$275 copayment
06211 - Pontic, cast base metal (1 tooth per 5 years)	$275 copayment
06212 - Pontic, cast noble metal (1 tooth per 5 years)	$275 copayment
06240 - Pontic, porcelain to high noble metal (1 tooth per 5 years)	$275 copayment
06241 - Pontic, porcelain to base metal (1 tooth per 5 years)	$275 copayment
06242 - Pontic, porcelain to noble metal (1 tooth per 5 years)	$275 copayment
06750 - Crown, cast high noble metal (1 tooth per 5 years)	$275 copayment
06751 - Crown, cast base metal (1 tooth per 5 years) tooth per 5 years)	$275 copayment

Benefits chart – your covered services	**What you must pay** when you get these covered services
Prosthodontics (Fixed) - continued	
06752 - Crown, cast noble metal (1 tooth per 5 years) years)	$275 copayment
06790 - Crown, full cast to high noble metal (1 tooth per 5 years)	$275 copayment
06791 - Crown, full cast to base metal (1 tooth per 5 years)	$275 copayment
06792 - Crown, full cast to noble metal (1 tooth per 5 years)	$275 copayment
Oral Surgery	
07140 - Extraction, erupted tooth or exposed root	$50 copayment
07210 - Surgical removal of tooth	$70 copayment
07220 - Removal, impacted soft tissue	$70 copayment
07230 - Removal, impacted partially bony	$95 copayment
07240 - Removal, impacted completely bony	$120 copayment
07310 - Alveoloplasty in conjunction with extraction, per quadrant	$100 copayment
Miscellaneous	
09110 - Palliative (emergency) treatment	$41 copayment
09230 - Analgesia (nitrous oxide per 15 min)	$15 copayment
For services not listed above, you will receive 25% off the plan general dentist's usual and customary fees.	

Benefits chart – your covered services	**What you must pay** when you get these covered services
Health and wellness education programs The plan covers the following health and wellness education benefits: • Written health education materials, including newsletters. • A nursing hotline. **Blueprint for Health programs** We have established (and from time to time establish) various customer-focused health education and information programs, as well as benefit utilization management and utilization review programs. These programs, collectively called the Blueprint for Health programs, are designed to: 1. provide you with information that will help you make more informed decisions about your health; 2. help us facilitate the management and review of coverage and benefits provided under our policies; and 3. present opportunities to mutually agree upon alternative benefits or payment alternatives for cost-effective, medically appropriate health care services. **Member-focused programs** These Blueprint for Health programs may include health information that supports member education and choices for health care issues. These programs focus on keeping you well, help identify early preventive treatment measures and help members with chronic problems enjoy lives that are as productive and healthy as possible. These programs may include illness management programs for conditions such as diabetes, cancer and heart disease. These programs are voluntary and are designed to enhance your ability to make informed choices and decisions for your unique health care needs. You may call the toll-free Member Services phone number on your plan membership card for more information. Your participation in these programs is completely voluntary.	• $0 copayment for these services

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section, and later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Member Services to request one.

How much do you pay for drugs covered by this Plan?

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, the period after you reach your initial coverage limit and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the coinsurance or copayment. Your coinsurance or copayment will vary depending on the drug and where the prescription is filled.

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (31-day supply)	Network Retail Cost-Sharing (90-day supply)	Network Long-Term Care Cost-Sharing (31-day supply)	Network Mail-Order Cost-Sharing (31-day supply)	Network Mail-Order Cost-Sharing (90-day supply)	Out-of-Network Cost-Sharing (31-day supply)
Tier 1 – Covered Generic	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment	$0 copayment
Tier 2 – Covered Preferred Brand	$40 copayment	$120 copayment	$40 copayment	$40 copayment	$80 copayment	$40 copayment
Tier 3 – Covered Brand	$83 copayment	$249 copayment	$83 copayment	$83 copayment	$166 copayment	$83 copayment
Tier S – Covered Specialty	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance	33% coinsurance

Once your total drug costs reach $2,700, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit.

We offer 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 formulary.

Coverage Gap

After your total drug costs reach $2,700, you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $4,350, and you qualify for catastrophic coverage.

Once your total out-of-pocket costs reach $4,350, you will qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,350 out-of-pocket for the year. When the total amount you have paid toward coinsurance or copayments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of 5%

coinsurance or $2.40 for generics or drugs that are treated like generics and $6.00 for all other drugs. We will pay the rest.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your initial coverage limit or total out-of-pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

Vaccine Coverage (including administration)

Our Plan's prescription drug benefit covers a number of vaccines, including vaccine administration. The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during the coverage gap phase of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or copayment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or copayment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay your normal coinsurance or copayment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Member Services.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your coinsurance or copayments up to the initial coverage limit
- Any payments you make for drugs in the coverage gap
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of $4,350 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Non-Part D drugs that are covered under our additional coverage but are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will also not count towards your initial coverage limit. There is information later in this section on the excluded non-Part D drugs we may cover as part of our additional coverage.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items or drugs that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, or anywhere else in this EOC, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare & Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the

bathroom, preparation of special diets, and supervision of medication that is usually self-administered.

9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
14. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines.
15. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
16. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
17. Hearing aids and routine hearing examinations.
18. Eyeglasses (except after cataract surgery), routine eye examinations, radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
19. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
20. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
21. Acupuncture.
22. Naturopath services.
23. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
24. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Excluded Drugs

This part of Section 10 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

In addition, by law, certain types of drugs or categories of drugs are not normally covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Non-prescription drugs (or over-the counter drugs)	Drugs when used for treatment of anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or to promote hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
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	Barbiturates and Benzodiazepines
Drugs, such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction	

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. Our plan covers generic-only prescriptions for the following types of drugs: benzodiazepines, barbiturates and drugs used to relieve cough and cold symptoms. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay

for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary or call Member Services for more information.

If you receive extra help, 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.

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