Terms and Conditions of Participation in FreedomBlue[SM]
Private Fee for Service Plans

FreedomBlue Medicare Advantage Private Fee-For Service ("FreedomBlue PFFS") is a Medicare Advantage Plan offered by Highmark Health Insurance Company (HHIC), a subsidiary of Highmark Inc, in association with Mountain State Blue Cross Blue Shield. It has been authorized by the Centers for Medicare & Medicaid Services (CMS) and is being offered to Medicare beneficiaries in 55 West Virginia counties.

- FreedomBlue PFFS is a non-network PFFS product. Authorizations or referrals are not required.
- It covers all services covered by Medicare plus some additional services that Medicare does not.
- Except for pharmacies, Highmark does not contract with physicians or other providers for FreedomBlue PFFS. Physicians and providers choose whether or not they want to become "deemed" providers and as a result, eligible to be reimbursed for treating FreedomBlue PFFS members.

Provider Deeming

Providers, both Medicare participating and non-participating, are considered deemed when they meet the following conditions:

1) Are aware in advance that the patient is a FreedomBlue PFFS member. All FreedomBlue PFFS members receive an identification card that includes the FreedomBlue PFFS logo to help identify them as PFFS members. The provider may further validate eligibility by calling our Provider Service Center at 1-866-675-8632; and
2) Have a copy of or reasonable access to FreedomBlue PFFS's Terms and Conditions of participation. The Terms and Conditions are available on our Web site at www.highmarkhealth.com, which is listed on the FreedomBlue PFFS member's identification card, or by calling our Provider Service Center at 1-866-675-8632; and
3) Provide services covered by FreedomBlue to a FreedomBlue PFFS member.

It is important to emphasize that although a provider may choose to provide, or not provide services, on a case by case basis to FreedomBlue PFFS members, a provider automatically becomes deemed and automatically agrees to FreedomBlue's PFFS Terms and Conditions of Participation once plan covered services are rendered to a FreedomBlue PFFS member and the other deeming conditions listed above have been met. For example, if a FreedomBlue PFFS member shows you an enrollment card identifying him as a member of FreedomBlue PFFS and you provide services to that member, you will be considered a "deemed" provider. It is your responsibility to access and review these Terms and Conditions.

Additional Provider Requirements

In addition, to provide care to a FreedomBlue PFFS member, providers must:

- Be state licensed and acting within the scope of that license;
- Have a Medicare billing number and not be sanctioned by Medicare or have opted out of Medicare;
- Agree to not balance-bill the member and only collect applicable member cost-sharing amounts – except for certain services covered by FreedomBlue PFFS where the member is only entitled to a specific allowance towards the benefit;
- Adhere to all applicable state and federal requirements;
- Follow the standards for confidentiality and patient privacy rights outlined in the Health Insurance Portability Access and Accountability Act (HIPAA) and the Medicare Advantage regulations; and
- Comply with all Medicare and other federal health care program laws, regulations and program instructions that apply to the services furnished to members, including inspections and audits.

- Provide medical records as requested by Highmark for advance coverage determinations, to determine coverage or medical necessity, and for billing or other plan-determined uses consistent with federal and sate regulations. Provide medical records as required by CMS for risk adjustment and validation as outlined in 42 CFR 422.310(e).

Providers that do not accept the Terms and Conditions will only be paid if they treat a FreedomBlue PFFS member for urgent or emergency care. You may only collect any applicable member co-payments or coinsurance and cannot balance bill the member.

Hold Harmless Provision

In no event, including but not limited to, non-payment by Highmark or an intermediary, or breach by Highmark of these Terms and Conditions, will the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement or have any recourse against members of FreedomBlue PFFS or person (other than FreedomBlue PFFS or an intermediary) on behalf of a member for health services provided under this agreement.

Claims Submission

Providers agree to bill all services in accordance with Medicare billing guidelines and other Medicare and CMS requirements.

- FreedomBlue PFFS claims will be processed in accordance with original Medicare billing rules.
- To submit claims **electronically**, call Highmark EDI Operations at 1-800-992-0246 for technical assistance. Highmark's EDI Payer ID number is 54771.
- Providers outside of Pennsylvania should submit claims, either electronic or paper, to their local Blue Cross Blue Shield plan, using the alpha prefix HKP.
- **Paper claims** may be submitted to:

  FreedomBlue PFFS
  20th & Chapline Street
  P.O. Box 7026
  Wheeling, WV 26003-0766

Claims Payment

In general, Highmark's reimbursement to providers for covered services provided to FreedomBlue PFFS members will be determined in accordance with original Medicare rules and payment will be based on Medicare fee schedules or an equivalent amount. Highmark has not adopted CMS's Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) competitive bidding program and will continue to pay the Original Medicare rate for these services.

For access to Medicare fee schedules go to www.cms.hhs.gov/center/provider.asp. National Coverage Determinations and Local Medical Review Policies will apply. Local Medical Review Policies will apply based on where the service was provided.

- Providers should submit claims using the same coding rules as original Medicare, using Medicare CPT Codes, defined modifiers and diagnosis codes to the highest level of specificity.
- The total payment to which the provider is entitled will be that portion received from FreedomBlue PFFS and the member's cost sharing amount. For FreedomBlue PFFS covered services, unless otherwise stated, providers may only collect applicable member co-payment or coinsurance amounts. For services that are covered by original Medicare, providers that accept Medicare assignment may not balance bill the member for any greater amount than allowed by CMS regulations.
- Some services covered under FreedomBlue PFFS are not covered under Medicare. These services are priced using a Highmark-developed fee schedule and this amount will be considered payment in full.

For example, Highmark pays for eligible routine vision care, which Medicare does not, using a Highmark-developed fee schedule which the provider agrees to accept as payment in full.

- For access to the Highmark-developed fee schedule, go to www.highmarkhealth.com. If a Highmark developed rate does not exist, the provider can bill Highmark up to charges.
- For those services on which the member has a defined benefit allowance, the provider may bill the member the difference up to charges.
- For providers that do not accept Medicare assignment, Highmark will pay up to the limiting charge as determined by the Medicare fee schedule. The provider may not balance bill the member for amounts up to the limiting charge.
- FreedomBlue PFFS is not required to pay for services that are not considered to be medically necessary under Medicare rules or are otherwise not covered by Medicare or FreedomBlue PFFS.
- FreedomBlue PFFS will pay 95 percent of clean claims within 30 days of receipt if they are submitted by, or on behalf of, a FreedomBlue PFFS enrollee. Clean claims are those claims that have no defect, impropriety, do not require any substantiating documentation or particular circumstance requiring special treatment that prevents timely payment and a claim that otherwise conforms to the clean claim requirement for equivalent claims under original Medicare.

Payment Disputes

Medicare Advantage plans are not required to perform cost settlements. If the payment amount a provider receives from FreedomBlue PFFS, including the member cost-sharing collected, is less than what original Medicare would have paid for the service; the provider can appeal the payment amount. The provider must provide reasonable documentation of the original Medicare payment that applies to the service to Highmark.

Highmark will respond to most payment disputes within 14 business days, however, some disputes may take up to 60 days to resolve. Providers with questions about claims payment should call the Provider Service Center at 1-866-675-8632 between the hours of 8 a.m. to 8 p.m., Eastern Standard Time.

Advance Notice of Coverage

Members and providers have the right to seek an advance notice of coverage to determine whether a service would be covered by FreedomBlue PFFS. If a member is not sure whether a service will be covered, the member has the right to call the telephone number listed on the back of their FreedomBlue PFFS member identification card for benefit clarification. Providers should call the Provider Service Center at 1-866-675-8632.

Appeals and Grievances

The members of FreedomBlue PFFS, their physicians, or authorized representatives on their behalf may request an appeal of an adverse coverage determination made by FreedomBlue PFFS including when services are limited, not provided, not paid for or not allowed. This would also include an appeal regarding a delay in providing or approving drug coverage or services, or any cost sharing that the member is required to pay for a drug or a service.

For more information about Highmark's appeal process, please visit the Highmark Blue Shield Office Manual Chapter 4, Unit 4.

Medical appeals should be sent to:	**Medicare prescription drug coverage appeals should be sent to:**
FreedomBlue PFFS P.O. Box 1948 Parkersburg, WV 26102	FreedomBlue PFFS P.O. Box 535047 Pittsburgh, PA 15253-5047

For more information:

Visit our Web site at www.highmarkhealth.com or call the Provider Service Center at 1-866-675-8632. Hearing-impaired providers (or physicians) should call the TTY relay number in the state in which they are located.

To view covered benefits:

The FreedomBlue PFFS plan covers all benefits covered by Medicare and additional services such as routine vision and hearing that Medicare does not. Additional information on covered benefits is available at www.highmarkhealth.com or by calling 1-866-675-8632.