HIGHMARK.
FREEDOMBLUE PFFS
A Medicare Advantage Private Fee-for-Service Program

Highmark Blue Shield is an Independent Licensee of the Blue Cross and Blue Shield Association

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Highmark Blue Shield FreedomBlue PFFS

2008

Evidence Of Coverage

January 1 – December 31

Highmark Blue Shield FreedomBlue PFFS Member Service:
For help or information, please call Member Service or go to our Plan Web site at www.highmark.com.

1-866-675-8634—or the Member Service number on your FreedomBlue PFFS identification card (Calls to these numbers are free) **TTY users call: 1-800-988-0668**

Hours of Operation:
Monday through Sunday, 8:00 a.m. to 8:00 p.m.

This booklet gives the details about your Medicare health and prescription drug coverage and explains how to get the prescription drug and health care you need. This booklet is an important legal document. Please keep it in a safe place.

H9793_71098
CMS APPROVAL (11/2007)

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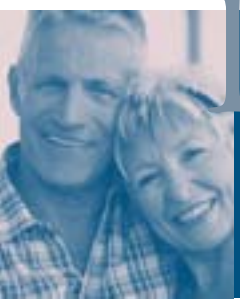
A Medicare Advantage Private Fee-for-Service Program



1 Introduction

Contact Information

Telephone Numbers and Other Information for Reference

How to Contact Our Plan Member Service

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

CALL **1-866-675-8634**—or the toll-free Member Service number on your FreedomBlue PFFS identification card, Monday through Sunday, 8:00 a.m. to 8:00 p.m. This number is also on the cover of this booklet for easy reference. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

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

VISIT Penn Avenue Place
501 Penn Avenue, Ground Floor
Pittsburgh, PA 15222

One Pasquerilla Plaza
Johnstown, PA 15901

717 State Street
Erie, PA 16501

Building #1, Level 1-A
1800 Center Street
Camp Hill, PA 17011

7248 Tilghman Street
Allentown, PA 18106

2040 Sandy Drive
State College, PA 16801

WEB SITE **www.highmark.com**

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

Part C Organization Determinations

CALL **1-866-675-8634**—or the Member Service number on your FreedomBlue PFFS identification card, Monday through Sunday, 8:00 a.m. to 8:00 p.m. Calls to this number are free. To file an expedited organization determination, call 1-800-485-9610. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free. To file an expedited organization determination, call 1-888-422-1226. This number also requires special telephone equipment. Calls to this number are free.

FAX **1-800-894-7947**

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

To file an expedited organization determination, send your request to:

Highmark Blue Shield
Expedited Review Department
P.O. Box 535073
Pittsburgh, PA 15253-5073

For information about Part C appeals, see Section 9.

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Part C Grievances

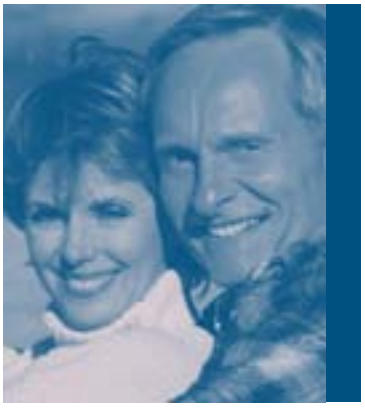
CALL **1-866-675-8634**—or the Member Service number on your FreedomBlue PFFS identification card. Calls to this number are free. For expedited grievance requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), call 1-800-485-9610. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free. For expedited grievance requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), call 1-888-422-1226. This number also requires special telephone equipment. Calls to this number are free.

FAX **1-412-544-1513**

WRITE
Highmark Blue Shield Appeals and Grievance Department
P.O. Box 535047
Pittsburgh, PA 15253-5047

For information about Part C grievances, see Section 8.



Part C Appeals

CALL **1-866-675-8634**—or the Member Service number on your FreedomBlue PFFS identification card, Monday through Sunday, 8:00 a.m. to 8:00 p.m. Calls to this number are free. To file an expedited appeal, call 1-800-485-9610. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free. To file an expedited appeal, call 1-888-422-1226. This number also requires special telephone equipment. Calls to this number are free.

FAX **1-412-544-1513.** To file an expedited appeal, fax your request to 1-800-894-7947.

WRITE
Highmark Blue Shield Appeals and Grievance Department
P.O. Box 535047
Pittsburgh, PA 15253-5047

For expedited appeals, please send your written request to:

Highmark Blue Shield Expedited Review Department
P.O. Box 535073
Pittsburgh, PA 15253-5073

For information about Part C appeals, see Section 9.

Part D Coverage Determinations

CALL **1-866-675-8634**—or the Member Service number on your FreedomBlue PFFS identification card. Calls to this number are free. For requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), please call the above numbers and select prompt 5.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free.

FAX **1-412-544-7546**

WRITE
Highmark Inc. Pharmacy Affairs
P.O. Box 279
Pittsburgh, PA 15230

For information about Part D coverage determinations, see Section 10.

Part D Grievances

CALL **1-866-675-8634**—or the Member Service number on your FreedomBlue PFFS identification card. Calls to this number are free. For expedited grievance requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), call 1-800-485-9610. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free. For expedited grievance requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), call 1-888-422-1226. This number also requires special telephone equipment. Calls to this number are free.

FAX **1-412-544-1513**

WRITE **Highmark Blue Shield Appeals and Grievance Department**
P.O. Box 535047
Pittsburgh, PA 15253-5047

For information about Part D grievances, see Section 8.

Part D Appeals

CALL **1-866-675-8634—**or the Member Service number on your FreedomBlue PFFS identification card, Monday through Sunday, 8:00 a.m. to 8:00 p.m. Calls to this number are free. To file an expedited appeal, call 1-800-485-9610. Calls to this number are free.

TTY **1-800-988-0668.** This number requires special telephone equipment. Calls to this number are free. To file an expedited appeal, call 1-888-422-1226. This number also requires special telephone equipment. Calls to this number are free.

FAX **1-412-544-1513.** To file an expedited appeal, fax your request to 1-800-894-7947.

WRITE **Highmark Blue Shield Appeals and Grievance Department**
P.O. Box 535047
Pittsburgh, PA 15253-5047

For expedited appeals, please send your written request to:

Highmark Blue Shield Expedited Review Department
P.O. Box 535073
Pittsburgh, PA 15253-5073

For information about Part D appeals, see Section 10.

State Health Insurance Assistance Program (SHIP)—A State Program that Gives Free Local Health Insurance Counseling to People with Medicare

SHIP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost 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. This also includes special Medigap rights for people who have tried a Medicare Advantage Plan for the first time. Section 2 has more information about your Medigap guaranteed issue rights.

You may contact the SHIP in your state at:

Pennsylvania Department of Aging
APPRISE Health Insurance Counseling Program
1-800-783-7067, Monday through Friday,
9:00 a.m. to 4:00 p.m.

Employer group members who live outside Pennsylvania, please see the separate list of state contact information.

You may also find the Web site for your local SHIP at www.medicare.gov on the Web. Under "Search Tools," select "Helpful Phone Numbers and Web sites."

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Quality Improvement Organization—A Group of Doctors and Health Professionals in Your State that Reviews Medical Care and Handles Certain Types of Complaints from Patients with Medicare

"QIO" stands for Quality Improvement Organization. The QIO 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 Section 9 for more information about complaints, appeals and grievances.

You may contact your state QIO at:

Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-877-346-6180

Employer group members who live outside Pennsylvania, please see the separate list of state contact information.

How to Contact the Medicare Program

Medicare is health insurance for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the Federal agency in charge of the Medicare Program. CMS contracts with and regulates Medicare Plans (including our Plan). Here are ways to get help and information about Medicare from CMS:

- **Call 1-800-MEDICARE (1-800-633-4227)** to ask questions or get free information booklets from Medicare. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- **Visit www.medicare.gov.** This is the official government Web site for Medicare information. This Web site 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 Web sites." If you don't have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Other Organizations (Including Social Security and Medicaid—A State Government Agency that Handles Health Care Programs for People with Limited Resources)

Medicaid 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:

Pennsylvania Department of Public Welfare
Health and Welfare Building, Room 515
P.O. Box 2675
Harrisburg, PA 17105
1-800-692-7462

Employer group members who live outside Pennsylvania, please see the separate list of state contact information.

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.

State Pharmacy Assistance Program (SPAP)—An Organization in Your State that Provides Financial Help for Prescription Drugs
SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact Pennsylvania Pharmaceutical Assistance Contract for the Elderly—PACE and PACENET programs at P.O. Box 8806, Harrisburg, PA 17105, or by calling 1-800-225-7223. TTY users, call 1-800-222-9004. You can also find the Web site for the PACE/PACENET program at www.aging.state.pa.us.

Employer group members who live outside Pennsylvania, please see the separate list of state contact information.

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 1-312-751-4701. You may also visit www.rrb.gov on the Web.

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

Welcome to FreedomBlue PFFS!

We are pleased that you've chosen our Plan.

FreedomBlue PFFS is a Medicare Advantage Private Fee-for-Service Plan.

Thank you for your membership in FreedomBlue PFFS; you are getting your health care and Medicare prescription drug coverage through our Plan. FreedomBlue PFFS is not a "Medigap" Medicare supplement insurance policy.

Throughout the remainder of this *Evidence of Coverage*, we refer to FreedomBlue PFFS as "Plan" or "our Plan."

This *Evidence of Coverage* explains how to get your health care and drug coverage through our Plan.

This *Evidence of Coverage*, together with your enrollment form, riders (including optional supplemental benefit brochures), Annual Notice of Change (ANOC), formulary, and amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a member of our Plan. The information in this *Evidence of Coverage* is in effect for the time period from January 1, 2008, - December 31, 2008.

You are still covered by Medicare, but you are getting your Medicare services as a member of our Plan.

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.

If you need this *Evidence of Coverage* in a different format (such as in audio format), please call us so we can send you a copy.

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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. If you currently pay a premium for Medicare Part A and 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.

Use Your Plan Membership Card, Not Your Red, White, and Blue Medicare Card

Now that you are a member of our Plan, you must use our membership card for services covered by this plan *AND/OR* prescription drug coverage at network pharmacies. While you are a member of our Plan and using our Plan services, you *must* use your plan membership card instead of your red, white, and blue Medicare card to get covered services, items *AND/OR* drugs. (See Section 4 for information on Part D prescription coverage and Section 3 for information on covered services.) 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 card 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 card that we gave you at all times and remember to show your card when you get covered services, items *AND/OR* drugs. If your membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card.

Here is a sample card to show you what it looks like:

The FreedomBlue PFFS 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 Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

Explanation of Benefits

What Is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide.

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 affecting the prescriptions you have gotten filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
  - **Amount Paid For Prescriptions**— The amounts you 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 your qualifying for catastrophic coverage. This total includes the amounts spent for your copayment and coinsurance, 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.)

What Should You Do if You Don't Get an Explanation of Benefits or if You Wish to Request One?

An Explanation of Benefits is also available upon request. To get a copy, please contact Member Service.

How Do I Keep My Membership Record Up to Date?

We have a membership record about you as a plan member. Doctors, hospitals, pharmacists, and other plan providers use your membership record to know what services or drugs are covered for you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 6 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Member Service know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Service about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, Workers' Compensation, Medicaid, or liability claims such as claims from an automobile accident. Call Member Service at the number on the cover of this booklet.

The Geographic Service Area for Our Plan

The state and counties in our service area are listed below.

Pennsylvania Region 1 Counties:
Adams, Berks, Bradford, Carbon, Centre, Clinton, Columbia, Cumberland, Dauphin, Erie, Franklin, Fulton, Juniata, Lackawanna, Lancaster, Lebanon, Lehigh, Luzerne, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne, Wyoming, York

Pennsylvania Region 2 Counties:
Allegheny, Armstrong, Beaver, Bedford, Blair, Butler, Cambria, Crawford, Fayette, Greene, Indiana, Lawrence, Mercer, Somerset, Washington, Westmoreland, Cameron, Clarion, Clearfield, Elk, Forest, Huntingdon, Jefferson, McKean, Potter, Venango, Warren

Note: The above counties are listed for eligibility and enrollment purposes. To be eligible to enroll in a FreedomBlue PFFS individual direct payment plan, you must live in one of the above counties. Members of employer group or union sponsored plans are not required to live in one of the above counties.

2 How You Get Care and Prescription Drugs

Providers You Can Use to Get Services Covered by Our Plan

While you are a member of our Plan, you may use any provider in the United States eligible to participate in Medicare, who accepts our Plan's terms and conditions, and who agrees to provide you with services. See Section 2, under the subheading "Rules about Using Non-Plan Providers to Get Your Covered Services," for a complete description of using non-plan providers in a PFFS plan.

What Are Covered Services?

"Covered services" is the general term we use in this booklet to mean 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 3.

Rules about Using Non-Plan Providers to Get Your Covered Services

You may get services from any provider in the United States eligible to participate in the Medicare program and accepts our Plan. As soon as you have told your provider that you are a member of our Plan, for example, by showing them your plan ID card, and they agree to treat you, your provider is bound by the terms and conditions of payment of the Plan even if they don't explicitly accept them. We call these providers "deemed providers." Therefore, you should not pay more than the Plan cost sharing. We will pay the provider the remainder of his/her bill. The provider cannot change his/her mind about accepting the Plan's terms and conditions of payment after furnishing services.

How Do You Get Care from Doctors, Specialists and Hospitals?

You may go to any doctor or hospital in the United States that is eligible to participate in Medicare as long as they are willing to provide care and accepts our Plan's terms and conditions of payment. If a particular provider doesn't accept your plan's terms and conditions of payment you must get care from another provider who will. When you go to a doctor or hospital be sure to show them your Plan membership card. The card ensures that the provider has a reasonable opportunity to get the terms and conditions of payment under the Plan. If the doctor or hospital decides to treat you, you are only required to pay the cost-sharing amount allowed by our Plan. The doctor or hospital will bill us for the rest of its fee. You may call us in advance of getting health care services and we will provide a written advance coverage determination for the care you need. You may also ask us for a coverage decision in writing confirming if the service will be paid for by our Plan.

You may always ask us if you have questions about whether a certain service is covered by your plan or if a doctor or hospital may treat you. When you go to a doctor or hospital, for non-emergent care, you must inform the provider, by showing them your Member ID card that you are enrolled in our Plan—a Medicare Private Fee-for-Service Plan. If the doctor or hospital decides to treat you, you are only required to pay the cost-sharing amount allowed by our Plan. The doctor or hospital will bill us for the rest of the fee.

If you have any question whether we will pay for a service, including inpatient hospital services, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

What if the Doctor won't Treat You as a Member of Our Plan?

The rules for using providers in a PFFS plan were discussed above in Section 2 in the section "Rules about Using Non-Plan Providers to Get Your Covered Services." Please read this section carefully. As indicated there, sometimes a doctor, specialist, hospital, clinic, or other provider you are using might decide to not participate in our Plan. If this happens, you will have to choose another provider who is willing to treat you as a member of our Plan. If you need help finding a provider who will accept our Plan's terms and conditions of payment, please contact Member Service and we will provide assistance.

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 reasonably believe that your health is in serious danger—when every second counts. A medical emergency includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What Should You Do if You Have a Medical Emergency?

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.
- Make sure that we know about your emergency, because we need to be involved in following up on your emergency care. Once the crisis has passed, please contact FreedomBlue PFFS Member Service at the phone number listed in the Introduction or on your FreedomBlue PFFS identification card. We will help manage and follow up on your emergency care.

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, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines.

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. See Section 2 for filling prescriptions when you cannot access a network pharmacy.
- Medically necessary emergency medical care is also covered outside the United States. See the Benefits Chart in Section 3 for cost-sharing information. We cannot pay for any prescriptions that are filled by pharmacies outside the United States and its territories, even for a medical emergency.

Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. Medically necessary emergency ambulance services are also covered outside the United States when other means of transportation would endanger your health. See the Benefits Chart in Section 3 for cost-sharing information.

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 was not a medical emergency after all. If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible. The plan will pay for all medically necessary plan covered services furnished by the provider and covers non-emergency care that you get from any provider in the United States to whom you have informed, by showing your member ID card, that you are a plan member. (See Section 6 for more information on filling your prescription drugs when you are getting urgently needed care and when you are outside the Plan's service area.)

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What Is Urgently Needed Care? This Is Different from a Medical Emergency

Urgently needed care refers to a non-emergency situation where you are inside the United States, you are temporarily absent from the Plan's authorized service area, you need 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 Medicare Advantage Plan's participating provider network.

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?

Recall from our definition above that urgent care refers to care received outside the service area of the Plan. However, as discussed in detail in Section 2 in the section entitled "Rules about Using Non-Plan Providers to Get Your Covered Services", a PFFS plan allows enrollees to access care from any provider eligible for Medicare anywhere in the United States (Reread that section for important details on obtaining care). Consequently, the concept of urgent care does not apply in a PFFS setting since the enrollee may always obtain services independent of their location. **Note:** Non-emergency care obtained at an urgent-care center, may have different cost sharing than for other providers.

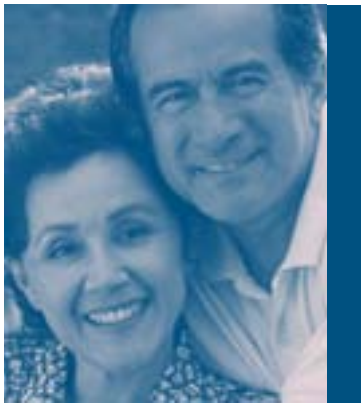
Hospital Care, Skilled Nursing Facility Care, and Other Services

How Do You Get Hospital Care?

If you need hospital care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 3 under the heading "Inpatient Hospital Care."

What Happens if You Join or Leave Our Plan During a Hospital Stay?

If you either join or leave our Plan during an inpatient hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Service. Member Service can explain how your services are covered for this stay, and what you owe to providers, if anything, for the periods of your stay when you were and were not a plan member.



What Is Skilled Nursing Facility (SNF) Care?

"Skilled nursing facility care" means 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 include 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.

How Do You Get Skilled Nursing Facility (SNF) Care?

If you need skilled nursing facility care, we will cover these services for you. Covered services are listed in the Benefits Chart in Section 3 under the heading "Skilled Nursing Facility Care." The purpose of this subsection is to tell you more about some rules that apply to your covered services.

Are Nursing Home Stays that Provide Custodial Care Covered?

"Custodial care" is 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. We don't 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.

What Are the Benefit Period Limitations on Coverage of Skilled Nursing Facility Care?

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A **"benefit period"** begins on the first day you are admitted as an inpatient at a Medicare-covered hospital or SNF. 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. See the Benefits Chart in Section 3 for cost-sharing information.

What Are the Situations When You May Be Able to Get Care in a Skilled Nursing Facility (SNF) that Isn't a Plan Provider?

You may obtain SNF services from any Medicare-qualified SNF in the United States willing to accept our terms and conditions of payment.

What Happens if You Join or Leave Our Plan During a Skilled Nursing Facility (SNF) Stay?

If you either join or leave our Plan during a SNF stay, please call Member Service. Member Service can explain how your services are covered for this stay, and what you owe, if anything, for the periods of your stay when you were and weren't a plan member.

How Do You Get Home Health Care?

Home health care is 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 3 under the heading "Home Health Care." If you need home health care services, we will cover these services for you provided the Medicare coverage requirements are met.

When Can Home Health Care Include Services from a Home Health Aide?

As long as some qualifying skilled nursing services are *also* included, the home health care you get can include services from a home health aide. A home health aide doesn't have a nursing license or provide therapy. The 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). The services from a home health aide must be part of the home care of plan for your illness or injury, and they aren't covered unless you are also getting a covered skilled nursing service. "Home health services" don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

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What Are "Part-Time" and "Intermittent" Home Health Care Services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part-time" or "intermittent" skilled nursing services and home health aide services:

- **"Part-time" or "intermittent"** means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What Is Hospice Care?

"Hospice" is 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 who qualify for hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

How Do You Get Hospice Care if You Are Terminally Ill?

As a member of our Plan, you may receive care from any Medicare-certified hospice program. Your doctor can help you arrange hospice care. If you are interested in using hospice services, you may call Member Service to get a list of the Medicare-certified hospice providers in your area or you may call the Regional Home Health Intermediary at 1-205-988-2100.

How Is Your Hospice Care Paid for?

If you enroll in a 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 plan provider or a non-plan provider. Even if you choose to enroll in a Medicare-certified hospice, 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.

How to Get More Information on Hospice Care

Visit www.medicare.gov on the Web. Under "Search Tools," "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.

How to Get an Organ Transplant if You Need it

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some hospitals that perform transplants are approved by Medicare, and others aren't). The Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. The following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

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.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. 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 that is unrelated to the clinical trial through our Plan.

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. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan. For instance, you will be responsible for Part B coinsurance—generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no coinsurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare coinsurance rules, called *Medicare & You.* To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web.

You don't need to get a referral (approval in advance) from a plan provider to join a clinical trial, and the clinical trial providers don't need to be plan 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 what services you will get from clinical trial providers and the cost for those services. You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov on the Web. 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 a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services, or care in a home health agency. You may get services when 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.) Medicare coverage limits apply.

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.

If You Are a Member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in an SPAP, you may get help paying your premiums, and copayments. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction section for more information.

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If You Have a Medigap (Medicare Supplement Insurance) Policy with Prescription Drug Coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If You Are a Member of an Employer or Retiree Group

If you currently have prescription drug coverage through your 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 (coverage that is at least as good as standard Medicare prescription drug coverage and expects to pay, on average, at least as much as the Medicare standard prescription drug plan expects to pay) 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 or union.

Using Network Pharmacies to Get Your Prescription Drugs Covered by Us

What Are Network Pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered**.

- **What is a "network pharmacy"?**
  A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drug. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you aren't required to continue going 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, 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.
- We have a list of retail pharmacies in our network at which you can obtain an extended supply of all medications. Please refer to your pharmacy directory or call Member Service to locate a retail pharmacy in our network at which you can obtain an extended supply of medications.
- **What are "covered 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.

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 **1-800-922-1557** to obtain the necessary information to pay the full cost of the prescription (rather than paying just your copayment or coinsurance). If this happens, 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".

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 Service to find another network pharmacy in your area.

How Do You Fill a Prescription through Our Plan's Network Mail-Order-Pharmacy Service?

You may use our network mail-order-pharmacy service to fill prescriptions for all formulary medications.

When you order prescription drugs through our network mail-order-pharmacy service, you must order up to a 90-day supply of the drug.

Generally, it takes the mail-order pharmacy six to 10 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If your mail-order shipment is delayed, please call Medco Health Solutions 24 hours a day, seven days a week at 1-800-903-6228 (TTY/TDD users should call 1-800-871-7138) to find out how you can get your prescription.

You aren't required to use our mail-order services to get an extended supply of mail-order medications. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail-order copayment or coinsurance for an extended supply of medications, for which you may not have to pay additional costs. Other retail pharmacies may provide an extended supply, but charge a higher copayment or coinsurance than our mail-order service. Please call Member Service to find out which retail pharmacies offer an extended supply.

Filling 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 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 Service 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 your copayment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay will help you qualify for catastrophic coverage.

Note: 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 a network pharmacy.

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

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

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

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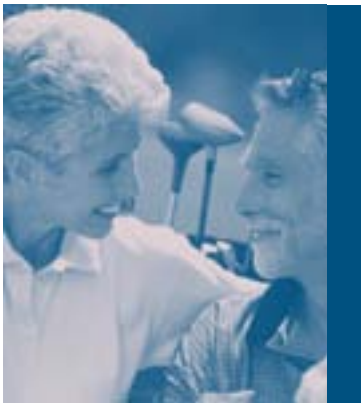
What if I need a prescription because of a medical emergency or because I needed urgent care?
We will cover prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to care for a medical emergency or urgent care. If you go to an out-of-network pharmacy, you may be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



Other times you can get your prescription covered if you go to an out-of-network pharmacy
We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and is administered in your doctor's office.
- If you were evacuated or displaced from your residence due to a state- or Federally-declared disaster or health emergency.

How Do You Submit a Paper Claim?

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 above, 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. Call FreedomBlue PFFS Member Service at the phone number listed in the Introduction or on your FreedomBlue PFFS identification card, Monday through Sunday, between 8:00 a.m. and 8:00 p.m., and request a paper claim form. Mail your completed claim form along with your prescription drug receipts to the address printed on the form. If you submit a paper claim to us, the claim is treated as a request for a coverage determination.

If you submit a paper claim asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 10 to learn more about requesting coverage determinations.

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 documentation and have it count towards qualifying you for catastrophic coverage. Additionally, if you get help from and pay copayments under a drug manufacturer patient assistance program outside our Plan's benefit, you may submit documentation for the amount you paid and have it count towards qualifying you for catastrophic coverage. Please call Member Service for more information.

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 benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we should cover your prescription drugs, we will cover them as long as the drugs meet all coverage requirements (such as the drugs being on our formulary, filled at a network pharmacy, etc.) and they aren't covered by our Plan's medical benefit.

We will also cover your prescription drugs if they are approved under the 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 stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network), unless you meet standards for out-of-network care, and that the drugs wouldn't otherwise be covered by our Plan's medical benefit. 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 or Prescription Drug Plan. Please see Section 11 of this booklet for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.

Long-Term Care Pharmacies

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

Home Infusion Pharmacies

Our plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under our Plan's medical benefit,
- Our plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

Please refer to your pharmacy directory to find a home-infusion-pharmacy provider in your area. For more information, please contact Member Service.

Some Vaccines and Drugs May Be Administered in Your Doctor's Office

We may cover vaccines that are preventive in nature (including the cost associated with administering the vaccine) and aren't already covered by our Plan's medical benefit. This coverage includes the cost of vaccine administration. (Please see Section 4, "How Does Your Enrollment in this Plan Affect Coverage for Drugs Covered Under Medicare Part A or Part B?" for more information.)

3 Covered Benefits

Covered Services

What Are "Covered Services"?

This section describes the medical benefits and coverage you get as a member of our Plan. **"Covered services" means the medical care, services, supplies, and equipment that are covered by our Plan**. This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. Section 7 tells about **services that aren't covered** (these are called "exclusions").

Note: Members of employer group or union sponsored plans, please see the separate *Schedule of Copayments and Coinsurance* specific to your plan.

There Are Some Conditions that Apply in Order to Get Covered Services

Some General Requirements Apply to All Covered Services

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. (See Section 13 for a definition of "medically necessary.")

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Inpatient Services	
Inpatient Hospital Care	
For more information about inpatient hospital care, see Section 2. There is no limit to the number of days covered by the plan each benefit period. Covered services include, but aren't limited to, the following: • Semiprivate 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 therapy, occupational therapy, and speech 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. See Section 2 for more information about transplants. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need—you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. • Physician services.	**FreedomBlue PFFS Enhanced Plan** • Days 1-4: $100 copayment per day per admission • $400 out-of-pocket limit per admission • Long-term Acute Care: $25 copayment per day **FreedomBlue PFFS Choice Plus Plan** • Days 1-4: $150 copayment per day per admission • $600 out-of-pocket limit per admission • Long-term Acute Care: $50 copayment per day **FreedomBlue PFFS Choice Plan** • Days 1-4: $125 copayment per day per admission • $500 out-of-pocket limit per admission • Long-term Acute Care: $50 copayment per day

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Inpatient Services	
Inpatient Mental Health Care	
Covered services include mental health care services that require a hospital stay. 190-day lifetime limit for inpatient services in a psychiatric hospital.	**FreedomBlue PFFS Enhanced Plan** • Days 1-4: $100 copayment per day per admission • $400 out-of-pocket limit per admission **FreedomBlue PFFS Choice Plus Plan** • Days 1-4: $150 copayment per day per admission • $600 out-of-pocket limit per admission **FreedomBlue PFFS Choice Plan** • Days 1-4: $125 copayment per day per admission • $500 out-of-pocket limit per admission
Skilled Nursing Facility Care	
For more information about skilled nursing facility care, see Section 2. No prior hospital stay is required. Covered services include, but aren't limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (This includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need—you pay for the first 3 pints of unreplaced blood. All other components of blood are covered beginning with the first pint used. Medical and surgical supplies. • Laboratory tests. • X-rays and other radiology services. • Use of appliances such as wheelchairs. • Physician services.	**FreedomBlue PFFS Enhanced Plan** • Days 1-10: $0 copayment per day per admission • Days 11-100: $25 copayment per day per admission **FreedomBlue PFFS Choice Plus Plan** • Days 1-10: $0 copayment per day per admission • Days 11-100: $50 copayment per day per admission **FreedomBlue PFFS Choice Plan** • Days 1-10: $0 copayment per day per admission • Days 11-100: $35 copayment per day per admission 100 days covered for each benefit period A benefit period starts the day you are admitted at a Medicare-covered hospital or skilled nursing facility. It ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go into the 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.

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Inpatient Services	
Inpatient Services (when the hospital or SNF days aren't or are no longer covered)	
For more information about inpatient services, see Section 2. Covered services include, but aren't limited to, the following: • 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. • Prosthetics and orthotics 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.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment for physician services • $20 copayment for basic diagnostic services • $75 copayment for advanced diagnostic services • 20% member coinsurance on durable medical equipment, prosthetics and orthotics and supplies • $15 copayment for each therapy service **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for physician services • $30 copayment for basic diagnostic services • $75 copayment for advanced diagnostic services • 20% member coinsurance on durable medical equipment, prosthetics and orthotics and supplies • $25 copayment for each therapy service **FreedomBlue PFFS Choice Plan** • $20 copayment for physician services • $25 copayment for basic diagnostic services • $75 copayment for advanced diagnostic services • 20% member coinsurance on durable medical equipment, prosthetics and orthotics and supplies • $20 copayment for each therapy service
Home Health Agency Care	
For more information about home health agency care, see Section 2. Covered services include, but aren't limited to, the following: • Part-time or intermittent skilled nursing and home health aide services. • Physical therapy, occupational therapy, and speech therapy. • Medical social services. • Medical equipment and supplies.	**FreedomBlue PFFS Enhanced Plan** • $10 copayment for each home health visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for each home health visit **FreedomBlue PFFS Choice Plan** • $15 copayment for each home health visit

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Inpatient Services	
Hospice Care	
For more information about hospice services, see Section 2. Covered services include, but aren't limited to, the following: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. Applicable office visit copayment may apply.	When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Medicare, not your Medicare Advantage Plan (see Section 2 for more information about hospice services).
Outpatient Services	
Physician Services (including Doctor Office Visits)	
Physician services, including doctor office visits Covered services include, but aren't limited to, the following: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center. • Consultation, diagnosis, and treatment by a specialist. • Second opinion 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). • Services provided by a primary care physician.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment per visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment per visit **FreedomBlue PFFS Choice Plan** • $20 copayment per visit

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Outpatient Services	
Chiropractic Services	
Covered services, include, but aren't limited to, the following: • Manual manipulation of the spine to correct subluxation.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment per visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment per visit **FreedomBlue PFFS Choice Plan** • $20 copayment per visit
Podiatry Services	
Covered services include, but aren't limited to, the following: • 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.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment per visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment per visit **FreedomBlue PFFS Choice Plan** • $20 copayment per visit
Outpatient Mental Health Care (including Partial Hospitalization Services)	
Covered services include, but aren't limited to, the following: • 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.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment for each individual or group therapy visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for each individual or group therapy visit **FreedomBlue PFFS Choice Plan** • $20 copayment for each individual or group therapy visit

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Outpatient Services	
Outpatient Substance Abuse Services	
	FreedomBlue PFFS Enhanced Plan • $15 copayment for each individual or group visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for each individual or group visit **FreedomBlue PFFS Choice Plan** • $20 copayment for each individual or group visit
Outpatient Surgery	
	FreedomBlue PFFS Enhanced Plan • $50 copayment per ambulatory surgical center visit or outpatient hospital facility visit **FreedomBlue PFFS Choice Plus Plan** • $100 copayment per ambulatory surgical center visit or outpatient hospital facility visit **FreedomBlue PFFS Choice Plan** • $75 copayment per ambulatory surgical center visit or outpatient hospital facility visit
Ambulance Services	
Covered services include ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911, where other means of transportation could endanger your health.	**FreedomBlue PFFS Enhanced Plan** • $25 copayment per one way trip **FreedomBlue PFFS Choice Plus Plan** • $50 copayment per one way trip **FreedomBlue PFFS Choice Plan** • $50 copayment per one way trip

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Outpatient Services	
Emergency Care	
For more information, see Section 2. Worldwide Coverage	**FreedomBlue PFFS Enhanced Plan** • $50 copayment per emergency room visit **FreedomBlue PFFS Choice Plus Plan** • $50 copayment per emergency room visit **FreedomBlue PFFS Choice Plan** • $50 copayment per emergency room visit If you are admitted to the hospital within 3 days for the same condition, you pay $0 for the emergency room visit. The $50 copayment applies if you are "admitted" for rapid treatment status (RTS), which is not considered a hospital inpatient admission.
Urgently Needed Care	
For more information, see Section 2. Worldwide Coverage	**FreedomBlue PFFS Enhanced Plan** • $50 copayment (hospital), $15 copayment (non-hospital) **FreedomBlue PFFS Choice Plus Plan** • $50 copayment (hospital), $25 copayment (non-hospital) **FreedomBlue PFFS Choice Plan** • $50 copayment (hospital), $20 copayment (non-hospital)
Outpatient Rehabilitation Services	
Covered services include, but aren't limited to, the following: • Physical therapy, occupational therapy, and speech and language therapy	**FreedomBlue PFFS Enhanced Plan** • $15 copayment per therapy type, per provider, per day **FreedomBlue PFFS Choice Plus Plan** • $25 copayment per therapy type, per provider, per day **FreedomBlue PFFS Choice Plan** • $20 copayment per therapy type, per provider, per day

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Outpatient Services	
Durable Medical Equipment and Related Supplies	
Such as wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 12.)	**FreedomBlue PFFS Enhanced Plan** • 20% member coinsurance for Medicare-covered items **FreedomBlue PFFS Choice Plus Plan** • 20% member coinsurance for Medicare-covered items **FreedomBlue PFFS Choice Plan** • 20% member coinsurance for Medicare-covered items
Prosthetic Devices and Related Supplies (other than Dental)	
That replaces 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" on page 33 for more detail.	**FreedomBlue PFFS Enhanced Plan** • 20% member coinsurance for Medicare-covered items **FreedomBlue PFFS Choice Plus Plan** • 20% member coinsurance for Medicare-covered items **FreedomBlue PFFS Choice Plan** • 20% member coinsurance for Medicare-covered items
Diabetes Self-Monitoring, Training and Supplies	
For all people who have diabetes (insulin and non-insulin users). Covered services include, but aren't limited to, the following: • 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. Fasting plasma glucose tests are covered 2 times per calendar year.	**FreedomBlue PFFS Enhanced Plan** • 20% member coinsurance for diabetic supplies and therapeutic shoes • $0 copayment for diabetic self-management training. Physician office visit copayment may apply. • $20 copayment for fasting plasma glucose test. **FreedomBlue PFFS Choice Plus Plan** • 20% member coinsurance for diabetic supplies and therapeutic shoes • $0 copayment for diabetic self-management training. Physician office visit copayment may apply. • $30 copayment for fasting plasma glucose test. *(continued)*

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Outpatient Services	
Diabetes Self-Monitoring, Training and Supplies *(continued)*	
	FreedomBlue PFFS Choice Plan • 20% member coinsurance for diabetic supplies and therapeutic shoes • $0 copayment for diabetic self-management training. Physician office visit copayment may apply. • $25 copayment for fasting plasma glucose test.
Medical Nutrition Therapy	
For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for medical nutrition therapy. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for medical nutrition therapy. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for medical nutrition therapy. Physician office visit copayment may apply.
Outpatient Diagnostic Tests and Therapeutic Services and Supplies	
Covered services include, but are not limited to, the following: • X-rays. • Radiation therapy. • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. • Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	**FreedomBlue PFFS Enhanced Plan** • $20 copayment basic diagnostic services • $75 copayment advanced imaging services • 20% member coinsurance for medical supplies • $0 copayment for blood **FreedomBlue PFFS Choice Plus Plan** • $30 copayment basic diagnostic services • $75 copayment advanced imaging services • 20% member coinsurance for medical supplies • $0 copayment for blood **FreedomBlue PFFS Choice Plan** • $25 copayment basic diagnostic services • $75 copayment advanced imaging services • 20% member coinsurance for medical supplies • $0 copayment for blood

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Preventive Care and Screening Tests	
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.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for bone-mass measurements. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for bone-mass measurements. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for bone-mass measurements. Physician office visit copayment may apply.
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.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for colorectal screening. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for colorectal screening. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for colorectal screening. Physician office visit copayment may apply.

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Preventive Care and Screening Tests	
Immunizations	
Covered services include, but aren't limited to, the following: • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • If you are at high or intermediate risk of getting Hepatitis B: Hepatitis B vaccine. • Other vaccines if you are at risk. • We also cover some vaccines under our outpatient prescription drug benefit.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for vaccines. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for vaccines. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for vaccines. Physician office visit copayment may apply. Immunizations and vaccines for the purpose of travel are not covered.
Mammography Screening	
Covered services include, but aren't limited to, the following: • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for mammograms. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for mammograms. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for mammograms. Physician office visit copayment may apply.
PAP Tests, Pelvic Exams, and Clinical Breast Exam	
Covered services include, but aren't limited to, the following: • 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.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for PAP test, $15 copayment for pelvic and clinical breast exams **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for PAP test, $25 copayment for pelvic and clinical breast exams **FreedomBlue PFFS Choice Plan** • $0 copayment for PAP test, $20 copayment for pelvic and clinical breast exams

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Preventive Care and Screening Tests	
Prostate Cancer Screening Exams	
For men age 50 and older, the following are covered once every 12 months. Covered services include, but aren't limited to, the following: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	**FreedomBlue PFFS Enhanced Plan** • $0 copayment for prostate cancer screening. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plus Plan** • $0 copayment for prostate cancer screening. Physician office visit copayment may apply. **FreedomBlue PFFS Choice Plan** • $0 copayment for prostate cancer screening. Physician office visit copayment may apply.
Cardiovascular Disease Testing	
Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Coverage provided once every 5 calendar years.	**FreedomBlue PFFS Enhanced Plan** • $20 copayment **FreedomBlue PFFS Choice Plus Plan** • $30 copayment **FreedomBlue PFFS Choice Plan** • $25 copayment
Physical Exams	
Limited to 1 physical exam every year.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment **FreedomBlue PFFS Choice Plus Plan** • $25 copayment **FreedomBlue PFFS Choice Plan** • $20 copayment

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Other Services	
Dialysis (Kidney)	
Covered services include, but aren't limited to, the following: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 2 and 3). • 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).	**FreedomBlue PFFS Enhanced Plan** • $0 copayment **FreedomBlue PFFS Choice Plus Plan** • $0 copayment **FreedomBlue PFFS Choice Plan** • $0 copayment
Prescription Drugs that Are Covered under the Original Medicare Plan (These Drugs Are Covered for Everyone with Medicare)	
"Drugs" includes substances that are naturally present in the body, such as blood-clotting factors. Covered drugs include, but aren't limited to, the following: • 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 Highmark Blue Shield. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare.	**FreedomBlue PFFS Enhanced Plan** • $25 copayment up to 34-day supply; $75 copayment up to 90-day supply **FreedomBlue PFFS Choice Plus Plan** • $25 copayment up to 34-day supply; $75 copayment up to 90-day supply **FreedomBlue PFFS Choice Plan** • $25 copayment up to 34-day supply; $75 copayment up to 90-day supply

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Other Services	
Prescription Drugs *(continued)*	
• 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, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®). • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.	
Drugs that Are Covered under the Medicare Prescription Drug Benefit (Part D)	
Section 4 explains the prescription drug benefit, including rules you must follow to have prescriptions covered. Section 7 also tells about drugs that are not covered by this benefit.	The FreedomBlue PFFS Enhanced and Choice Plus Plans include coverage for Medicare Part D drugs. The FreedomBlue PFFS Choice Plan does not include this coverage. Please refer to **Section 5** for your specific Medicare Part D drug cost sharing. Members of Employer Group or Union Sponsored Plans, please refer to your separate ***Schedule of Copayments and Coinsurance***.
Additional Benefits	
Dental Services	
Services by a dentist or oral surgeon 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 disease, or services that would be covered when provided by a doctor.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment per visit **FreedomBlue PFFS Choice Plus Plan** • $25 copayment per visit **FreedomBlue PFFS Choice Plan** • $20 copayment per visit

BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Additional Benefits	
Hearing Services	
• Diagnostic hearing exams. • Annual Routine hearing exams. • Hearing Aid allowance every 3 calendar years.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment for diagnostic hearing exam • $15 copayment for routine hearing exam • $500 allowance for hearing aids **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for diagnostic hearing exam • $25 copayment for routine hearing exam • $500 allowance for hearing aids **FreedomBlue PFFS Choice Plan** • $20 copayment for diagnostic hearing exam • $20 copayment for routine hearing exam • $500 allowance for hearing aids
Vision Care	
Covered services include, but aren't limited to, the following: • 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.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment for eye care and glaucoma screening **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for eye care and glaucoma screening **FreedomBlue PFFS Choice Plan** • $20 copayment for eye care and glaucoma screening $60 allowance for post cataract surgery eyeglass frames per operated eye $75 allowance for post cataract eyeglass lens or contact lens per operated eye *(continued)*

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BENEFITS CHART Your Covered Services	WHAT YOU MUST PAY When You Get These Covered Services
Additional Benefits	
Vision Care *(continued)*	
• Annual routine eye examination and refraction. • Routine contact lens examination and fitting every 2 years. • Routine eyeglass frames every 2 years. • Routine eyeglass lenses or contact lenses every 2 years.	**FreedomBlue PFFS Enhanced Plan** • $15 copayment for routine eye exam and contact lens fitting **FreedomBlue PFFS Choice Plus Plan** • $25 copayment for routine eye exam and contact lens fitting **FreedomBlue PFFS Choice Plan** • $20 copayment for routine eye exam and contact lens fitting $60 allowance for eyeglass frames every 2 years $75 allowance for eyeglass lenses or contact lenses every 2 years
The SilverSneakers® Fitness Program	
Is one of the nation's leading exercise programs designed exclusively for older adults. It is a unique physical activity, lifestyle, and social-oriented health and wellness program specifically designed for Medicare-eligible members of all fitness levels. FreedomBlue PFFS members receive a complimentary membership at a participating fitness center, plus access to any participating location across the United States. Members have free access to all amenities that are included with a basic fitness center membership. For members who live more than 15 miles from a participating center, you can still take advantage of the SilverSneakers Steps self-directed walking and physical activity program. You can locate participating SilverSneakers fitness centers by visiting www.silversneakers.com. Other health education and lifestyle improvement programs are available to FreedomBlue PFFS members.	At no additional cost above your FreedomBlue PFFS premium.

What if You Have Problems Getting Services You Believe Are Covered for You?

If you have any concerns or problems getting the services you believe are covered for you as a member, we want to help. Please call Member Service. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 9 for information about making a complaint.

Can Your Benefits Change During the Year?

Generally your benefits will not change during the year. The Medicare Program doesn't allow us to decrease your benefits during the calendar year. The only time your benefits may decrease is at the beginning of the next calendar year. The Medicare Program must approve any decreases we make in your benefits. We will tell you in November if there are going to be any increases or decreases in your benefits for the next calendar year that begins on January 1.

At any time during the year, the Medicare Program can change its national coverage. Since we cover what the Original Medicare Plan covers, we would have to make any change that the Medicare Program makes. If your benefits increase, the Original Medicare Plan will pay for the benefit for the rest of the calendar year. In those cases, you will have to pay the Original Medicare Plan out-of-pocket amounts for those services. We will let you know in advance if you will have to pay the Original Medicare Plan out-of-pocket costs for an increased benefit.

4 Prescription Drug (Part D) Benefits

What Is a Formulary?

We have a formulary that lists all 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 or through our network mail-order-pharmacy service 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. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand name drugs and generic drugs are included on the formulary. A generic drug has the same active ingredient as the brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In some cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See Section 2 for more information about filling a prescription at out-of-network pharmacies.

How Do You Find Out What Drugs Are on the Formulary?

You may call Member Service to find out if your drug is on the formulary or to request a copy of our formulary. You may also get updated information about the drugs covered by us by visiting our Web site www.highmark.com.

What Are Drug Tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance cost sharing 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 10 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 an appropriate drug that we cover or request a formulary exception before the change to the formulary takes effect. 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 from our formulary 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 the formulary, you should first contact Member Service to be sure it isn't covered.

If Member Service confirms that we don't cover your drug, you have three 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 Service or go to our formulary Web site (www.highmark.com).
2. You may ask us to make an exception (which is a type of coverage determination) to cover your drug. See Section 10 to learn more about how to request an exception.
3. You can pay out of pocket for the drug and request that the Plan reimburse you by requesting an exception (which is a type of coverage determination). This doesn't obligate the Plan to reimburse you if the exception request isn't approved. If the exception isn't approved, you may appeal the Plan's denial. See Section 10 for more information on how to request an appeal.

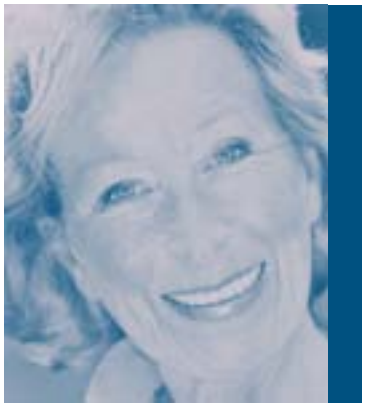
In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

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 in 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 an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See Section 10 (under "What is an Exception?") to learn more about how to request an exception. Please contact Member Service 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 an appropriate 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.



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For each of the drugs that isn't on our formulary or that has coverage restrictions or limits, we will cover a temporary 34-day supply (unless the prescription is written for fewer days) when a new member goes to a network pharmacy (and the drug is otherwise a "Part D drug"). After we cover the temporary 34-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 34-day transition supply (unless you have a prescription 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, when that member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in our Plan for more than 90 days, needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

The above transition policy will be implemented to accommodate you if you have an immediate need for a non-formulary drug or a drug that requires prior authorization due to a change in your level of care while you are waiting for an exception request to be processed.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are 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.

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.

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 authorized prescribers will need to get approval from us before you fill your prescription. If they don't get approval, 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 nine tablets per 34 days for Imitrex.

Generic Substitution:
When there is a generic version of a brand name drug available, our network pharmacies will automatically give 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 on our formulary Web site or by calling Member Service. 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 10 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 prescribe 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.

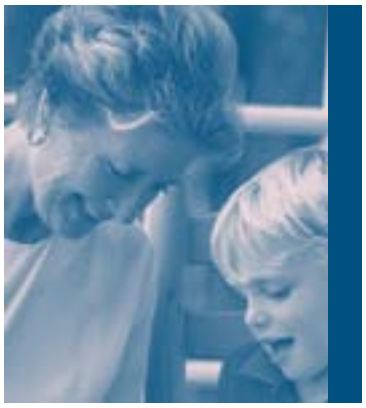
We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

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?

Your enrollment in this Plan doesn't affect Medicare coverage for drugs covered under Medicare Part A or Part B. Depending on the Medicare coverage criteria there may be some variation in the cost sharing applied to the drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B.



5 Your Costs for this Plan

Paying Your Monthly Plan Premium

As a member of our Plan, you pay:

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

How Much Is Your Monthly Plan Premium?

As a member of FreedomBlue PFFS you must pay a monthly plan premium, unless you qualify for extra help from Medicare.

The table below shows the monthly premium amount for each region we serve.

Region—Please see the Introduction, page 7 for a listing of Pennsylvania counties located in each region	FreedomBlue PFFS Choice Plan	FreedomBlue PFFS Choice Plus Plan	FreedomBlue PFFS Enhanced Plan
Region 1	$0	$0	$59
Region 2	$59	$62	$113

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your Plan premium.

Note: If you are getting extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs". Or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP to determine what benefits are available to you.

Paying the Plan Premium for Your Coverage as a Member of Our Plan

There are two ways to pay your monthly plan premium.

Option one: Pay your plan premium directly to our Plan.
Monthly invoices for your FreedomBlue PFFS premiums will be mailed on or about the 12th day of each month. Your payment is due on the 1st day of the following month. For example, your bill for February coverage will be mailed on or about January 12 and is due on February 1. You may pay your monthly premium by check or money order (no

cash), made payable to "FreedomBlue PFFS." Mail your payment to: Highmark Blue Shield, P.O. Box 382054, Pittsburgh, PA 15251-8054. If you prefer, you can drop off your payment in person at any of the Customer Service Centers listed in the Introduction section. Other billing frequencies may be available, such as quarterly or semi-annually. Please contact Member Service for more information.

Instead of paying by check, you can have your premium automatically withdrawn from your bank account. This automatic premium payment program, called "Pay-It-Easy," is easy to set up and convenient to use. Simply call Member Service and request an application. Automatic deductions are made monthly on or about the 1st day of each month.

Option two: You may have your monthly plan premium directly deducted from your monthly Social Security check.
You may choose this option if you can pay for the entire Medicare premium with your Social Security check. Contact Member Service for more information on how to pay your premium this way.

Note: We don't recommend that you choose this option if you are getting extra help for your premium payment from another payer, like a State Pharmaceutical Assistance Program (SPAP). Social Security can only withhold the full amount of the premium and will not recognize any premium payments made by other payers as part of this process.

Can Your Premiums Change During the Year?

Generally, your Plan premium can't change during the calendar year. We will tell you in advance if there will be any changes for the next calendar year in your Plan premiums or in the amounts you will have to pay when you get your prescriptions covered. If there are any changes for the next calendar year, they will take effect on January 1.

In certain cases, your Plan premium may change during the calendar year. If you aren't currently getting extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. Social Security or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help (see contact information in Section 1).

What Happens if You Don't Pay Your Plan Premiums, or Don't Pay Them on Time?

If your plan premiums are late, we will tell you in writing that if you don't pay your premium by the end of the 60-day grace period, we will end your membership in our Plan.

Should you decide later to re-enroll in our Plan, or to enroll in another plan offered by our Plan, you will have to pay any late plan premiums that you didn't pay from your previous enrollment in our Plan.

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Paying Your Share of the Cost When You Get Covered Services OR Drugs

What are "deductibles," "copayments," and "coinsurance"?

- The **"deductible"** is the amount you must pay for the health care services *OR* drugs you receive before our Plan begins to pay its share of your covered services *OR* drugs. Certain employer group or union sponsored plans may have a deductible. If you are a member of an employer group or union sponsored plan, please see your **separate *Schedule of Copayments and Coinsurance* for more information.**
- A **"copayment"** is a payment you make for your share of the cost of certain covered services *OR* drugs you get. A copayment is a set amount per service *OR* drug. You pay it when you get the service *OR* drug. The Benefits Chart in Section 3 gives your copayments for covered services. Copayments for prescription drugs are listed later in this section.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services *OR* drugs you receive. Coinsurance is a percentage of the cost of the service *OR* drug. You pay your coinsurance when you get the service *OR* drug. The Benefits Chart in Section 3 gives your coinsurance for covered services. Coinsurance for prescription drugs is listed later in this section.

What is the Maximum Amount You will Pay for Covered Services?

There is a limit to how much you have to pay out of pocket for your covered health care services each year. Once the total costs for your health care services, including your copayments, and coinsurance, reaches $3,000 for the FreedomBlue PFFS Enhanced Plan, $5,000 for the FreedomBlue PFFS Choice Plus Plan and $4,000 for the FreedomBlue PFFS Choice Plan, then you won't have to continue paying for these expenses for the remainder of the year.

How Much Do You Pay for Drugs Covered by this Plan?

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 "Do You Qualify for Extra Help?" later in this section, and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

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, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at a network or out-of-network pharmacy. Each phase of the benefit is described below.

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/copayment. Your coinsurance/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	Retail Copayment/ Coinsurance (Up to 34-day Supply)	Retail Copayment/ Coinsurance (Up to 90-day Supply)	Mail-Order Copayment/ Coinsurance (Up to 90-day Supply)	Out-of-Network Copayment/ Coinsurance
Generic	FreedomBlue PFFS Enhanced Plan $4 copayment FreedomBlue PFFS Choice Plus Plan $5 copayment	FreedomBlue PFFS Enhanced Plan $12 copayment FreedomBlue PFFS Choice Plus Plan $15 copayment	FreedomBlue PFFS Enhanced Plan $10 copayment FreedomBlue PFFS Choice Plus Plan $12.50 copayment	Difference between the out-of-network price and the network pharmacy price plus your applicable network copayment
Preferred Brand Name	FreedomBlue PFFS Enhanced Plan $29 copayment FreedomBlue PFFS Choice Plus Plan $36 copayment	FreedomBlue PFFS Enhanced Plan $87 copayment FreedomBlue PFFS Choice Plus Plan $108 copayment	FreedomBlue PFFS Enhanced Plan $72.50 copayment FreedomBlue PFFS Choice Plus Plan $90 copayment	Difference between the out-of-network price and the network pharmacy price plus your applicable network copayment
Non-Preferred Brand Name	FreedomBlue PFFS Enhanced Plan $60 copayment FreedomBlue PFFS Choice Plus Plan $66 copayment	FreedomBlue PFFS Enhanced Plan $180 copayment FreedomBlue PFFS Choice Plus Plan $198 copayment	FreedomBlue PFFS Enhanced Plan $150 copayment FreedomBlue PFFS Choice Plus Plan $165 copayment	Difference between the out-of-network price and the network pharmacy price plus your applicable network copayment
Specialty	FreedomBlue PFFS Enhanced Plan 25% coinsurance FreedomBlue PFFS Choice Plus Plan 25% coinsurance	FreedomBlue PFFS Enhanced Plan 25% coinsurance FreedomBlue PFFS Choice Plus Plan 25% coinsurance	FreedomBlue PFFS Enhanced Plan 25% coinsurance FreedomBlue PFFS Choice Plus Plan 25% coinsurance	Difference between the out-of-network price and the network pharmacy price plus your applicable network copayment

* Amounts in this chart may vary according to your individual out-of-network cost-sharing responsibility.

Once your total drug costs reach $2,510, 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.

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Coverage Gap

For FreedomBlue PFFS Choice Plus Plan Members:
After your total drug costs reach $2,510 you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $4,050, and you qualify for catastrophic coverage.

For FreedomBlue PFFS Enhanced Plan Members:
After your total drug costs reach $2,510, we will continue to provide some prescription drug coverage until your total out-of-pocket costs reach $4,050. You or others on your behalf will pay: $4 for generic drugs and 100% for all other drugs. Once your total out-of-pocket costs reach $4,050, 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 $4,050 out of pocket for the year. When the total amount you have paid toward copayments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,050, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of $2.25 for generics or drugs that are treated like generics and $5.60 for all other drugs or 5% coinsurance. We will pay the rest.

Vaccines (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 then need to mail us the receipts, and then you will be reimbursed. 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 any deductible or coverage gap phases of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	**The Pharmacy (not possible in all states)**	You pay the applicable drug copayment.
Your Doctor	**Your Doctor**	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less the applicable drug copayment plus any difference between the amount the doctor charges and what we normally pay. Or, if your doctor agrees to submit your claim on your behalf, you pay the applicable drug copayment plus any difference between the amount the doctor charges and what we normally pay.*
The Pharmacy	**Your Doctor**	You pay the applicable drug copayment at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less the applicable drug copayment plus 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, especially before you go to your doctor. For more information, please contact Member Service.

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 so 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 annual deductible;
- Your coinsurance or copayments;
- Payments you make after the initial coverage limit.

When you have spent a total of $4,050 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?

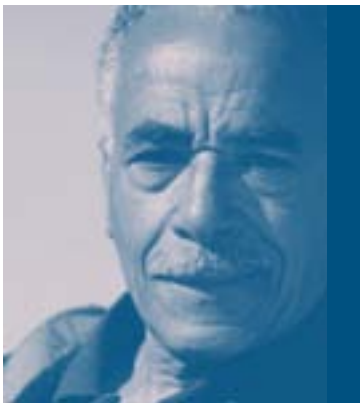
The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs will not count toward your out-of-pocket costs:

- 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.

Who Can Pay for Your Prescription Drugs, and How Do these Payments Apply to Your Out-of-Pocket Costs?

Except for your premium payments, 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;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- 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 disclose this information to us.

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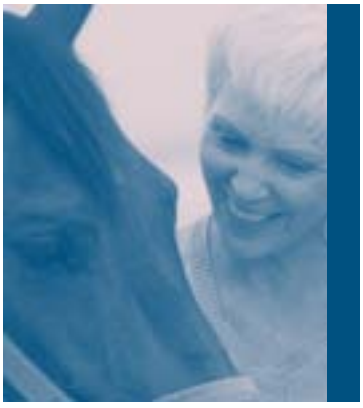
We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that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



What Extra Help Is Available?

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 your 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 letters monthly to people who automatically qualify for extra help.
2. **You apply and qualify.** You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). 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, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. 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 2007 and will change in 2008. 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?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, and prescription copayments. The amount of extra help you get is based on your income and resources.

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 provide evidence of your proper copayment level. Please call FreedomBlue

PFFS Member Service at 1-866-675-8634, Monday through Sunday, 8:00 a.m. to 8:00 p.m. if you believe you qualify for extra help and are not being charged the correct copayment amount. Hearing-impaired TTY users call 1-800-988-0668. You will need to provide Highmark Blue Shield with evidence confirming your eligibility for extra help. Documentation confirming your eligibility for extra help include but are not limited to the following: a copy of your Medicaid card which includes your name and eligibility date, a copy of a state document that confirms active Medicaid status, a copy of a remittance from a nursing facility showing Medicaid payment, a copy of a state document that confirms Medicaid payment to a nursing facility.

Please be assured that if you overpay your copayment, we will generally 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 Service if you have questions.

What Is Your Cost for Services that Aren't Covered under Our Plan?

You are responsible to pay the full cost of care and 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.

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 Service and tell us you would like a decision on whether the service will be covered.

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, unless your plan offers, as a covered supplemental benefit, coverage beyond the Original Medicare limits. For example, you may have to pay the full cost of any skilled nursing facility care or costs for hearing aids or eyewear you get after our Plan's payments reach the benefit limit. Any amount that you pay after a benefit limit has been reached will not count towards your annual out-of-pocket maximum. You can call Members Service when you want to know how much of your benefit limit you have already used.

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. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

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You Are Required to Tell Our Plan if You Have Additional Health Insurance *OR* Drug Coverage

Important Information about Medicare Prescription Drug Coverage

We will send you the CMS Secondary Payer Survey so that we can know what other drug coverage you have in addition to the coverage you get through this 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 drug coverage, you are required to 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 prescription drug coverage, please call Member Service to update your membership records.

You must tell us if you have any other health insurance coverage *OR* prescription drug coverage besides our Plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

- Coverage that you have from an employer's group health insurance for employees or retirees, either through yourself or your spouse.
- Coverage that you have under Workers' Compensation because of a job-related illness or injury, or under the Federal Black Lung Program.
- Coverage you have for an accident where no-fault insurance or liability insurance is involved.
- Coverage you have through Medicaid.
- Coverage you have through the "TRICARE for Life" program (Veteran's benefits).
- Coverage you have for dental insurance.
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions).

What Should You Do with Your Provider Bills?

You should never pay the provider more than the cost sharing allowed by our Plan. You should ask your provider to bill us for the rest of his or her fee and we will pay him or her according to our Plan terms and conditions of payment. If the provider asks you to pay the remainder of the bill and have you directly reimbursed from the Plan, tell him or her that you only have to pay the cost-sharing amount. Your enrollment card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us at 1-866-675-8635. They can also go to www.highmarkblueshield.com and visit the Provider Resource Center.

If you get a bill for the services, you may send the bill to us for payment. However, if you have already paid for the covered services we will reimburse you for our share of the cost. We will pay your doctor for our share of the bill and will let you know if you must pay any cost sharing.

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 you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, 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 percent of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). 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 Service to find out more about the reconsideration process and how to ask for such a review.

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

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was *not* creditable
- You lived in an area affected by Hurricane Katrina 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 AND you join a Medicare Prescription Drug Plan by December 31, 2007, AND you stay in a Medicare Prescription Drug Plan

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after

6 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. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, or visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." Under "Search Tools," select "find a Medicare Publication." If you have any questions whether our Plan will pay for a service, including inpatient hospital services, and including services obtained from providers not affiliated with our Plan, you have the right under law to have a written/binding advance coverage determination made for the service. Call us and tell us you would like a decision if the service or item will be covered.

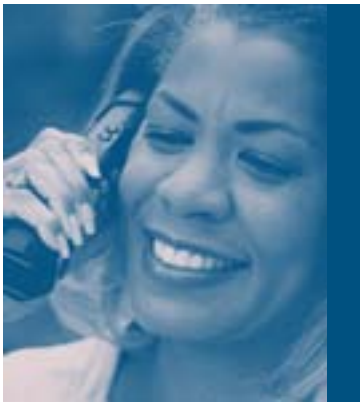
Your Right to Be Treated with Dignity, Respect and Fairness

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 Service at the phone number in Section 1. Member Service 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 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. For example, 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 Service at the phone number in Section 1 of this booklet. 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.



Your Right to See Plan 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 licensed providers who have agreed to treat you under our Plan terms and conditions of payment. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and accepts our Plan terms and conditions of payment. You also have the right to timely access to your prescriptions at any network pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need.

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 Management Treatment 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 are discussed in Section 9. Coverage determinations are discussed in Section 10.

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. Section 1 of this booklet tells how to contact your SHIP, which stands for State Health Insurance Assistance Program. 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.

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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:

For Complaints about Doctors:
Department of State
Bureau of Professional and Occupational
Affairs Complaints Office
P.O. Box 2649
Harrisburg, PA 17105-2649
1-800-822-2113

For Complaints about Hospitals:
Pennsylvania Department of Health
Division of Acute and Ambulatory Care
H&W Building
Room 352
Harrisburg, PA 17120
1-877-PAHEALTH

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. A complaint can be called a grievance, an organization determination, or a coverage determination depending on the situation. See Section 8 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 Service.

Your Right to Get Information about Our Plan, Plan Providers, Drugs, Health Care Coverage, and Costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay.

If you need more information, please call Member Service at the number in Section 1 of this booklet. You have the right to an explanation from us about any bills you may get for services not covered by our Plan. *We must tell you in writing why we will not pay for or approve a service, and how you can file an appeal to ask us to change this decision.* See Section 9 and Section 10 for more information about filing an appeal.

You also have the right to get information from us about our Plan. This includes information about our financial condition, about information on our network pharmacies, and how our Plan compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of this information, call Member Service at the phone number in Section 1 of this booklet. You have the right under law to have a written/binding advance coverage determination made for the service, even if you obtain this service from a provider not affiliated with our organization.

How to Get More Information about Your Rights

If you have questions or concerns about your rights and protections, please call Member Service at the number in Section 1 of this booklet. You can also get free help and information from your SHIP (contact information for your SHIP in Section 1 of this booklet). You can also visit www.medicare.gov on the Web to view or download the publication "Your Medicare Rights & Protections." 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.

What to 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 Service 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 (contact information for your SHIP is in Section 1 of this booklet).

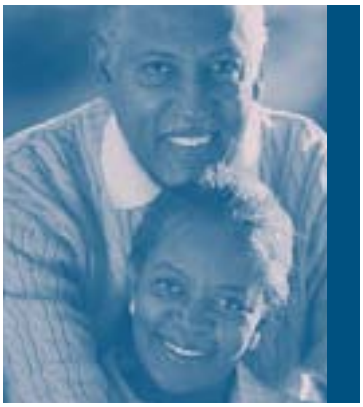
Your Responsibilities as a Member of Our Plan

Your responsibilities include the following:

- 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. Please call Member Service if you have any questions.
- Letting us know if you have additional health insurance coverage.
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan enrollment 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 plan premiums and your copayments/coinsurance for your covered services. You must pay for services that aren't covered.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Service at the phone number in Section 1 of this booklet.

Your Right to Get Information about Your Drug Coverage and Costs

This *Evidence of Coverage* tells you what you have to pay for prescription drugs as a member of our Plan. If you need more information, please call our Member Service numbers in Section 1. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an appeal to ask us to change this decision. See Section 10 for more information about filing an appeal. You also have the right to receive an explanation from us of any utilization-management requirements, such as step therapy or prior authorization that may apply to your plan. If you have any questions please review your formulary Web site or call Member Service.



Your Right to Get Information about Our Plan and Our Network Pharmacies

You have the right to get information from us about our Plan. This includes information about our financial condition and about our network pharmacies. To get any of this information, call Member Service at the phone number shown in Section 1.

7 General Exclusions

Introduction

The purpose of this section is to tell you about medical care and services, items AND/OR drugs that aren't covered ("excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items AND/OR drugs that aren't covered under any conditions.

If You Get Services, Items AND/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 booklet), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items *AND/OR drugs* that we should have paid or covered (appeals are discussed in Section 9 and Section10).

What Services Are Not Covered or Are Limited by Our Plan?

If you have any questions whether our Plan will pay for a service, including inpatient hospital services, you have the right under law to have a written/binding advance coverage determination made for the service. Call our Plan and tell us you would like a decision if the service or item will be covered.

In addition to any exclusions or limitations described in the Benefits Chart in Section 3, or anywhere else in this booklet **the following items and services aren't covered except as indicated by our Plan:**

1. Services that aren't covered under the Original Medicare Plan.
2. 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.
3. 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. In 2008 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 MA 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.
4. Surgical treatment of morbid obesity *unless* medically necessary and covered under the Original Medicare Plan.
5. Private room in a hospital, *unless* medically necessary.
6. Private duty nurses.
7. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
8. Nursing care on a full-time basis in your home.
9. Custodial care unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. "Custodial care" 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.
10. Homemaker services.
11. Charges imposed by immediate relatives or members of your household.
12. Meals delivered to your home.
13. 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.
14. 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 the unaffected breast, to produce a symmetrical appearance.

15. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered.
16. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in Section 3) and is limited according to Medicare guidelines.
17. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
18. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
20. Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. 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.
26. 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.

Drug Exclusions

A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B. Also, while 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, we cover the off-label use 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.*1* 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.

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:

Nonprescription 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	

1 These reference books are: (1) American Hospital Formulary Service Drug Information, (2) the DRUGDEX Information System, and (3) USPDI (or its successor).

8 How to File a Grievance

What Is a Grievance?

A grievance is any complaint, other than one that involves a request for an organization determination, a coverage determination, or an appeal, as described in Section 9 ***OR*** Section 10 of this manual because grievances do not involve problems related to approving or paying for care ***OR*** Part D benefits, 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 give you the services and/or 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 9 and/or 10.

What Types of Problems Might Lead to Your Filing a Grievance?

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- Problems with the service you receive from Member Service.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems with how long you have to wait in a network pharmacy.
- Problems getting appointments when you need them, or waiting too long for them.
- Waiting too long for prescriptions to be filled.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Rude behavior by network pharmacists or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- Cleanliness or condition of network pharmacies.
- 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 more detail in Section 9 ***OR*** Section 10.
- You believe our notices and other written materials are hard to understand.
- We don't give you a decision within the required time frame (on time).
- We don't forward your case to the independent review entity if we do not give you a decision on time.
- We don't give you required notices.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss fast grievances in more detail in Section 9 and/or Section 10.

Filing a Grievance with Our Plan

If you have a complaint, please call the phone number for **Part C Grievances** and/or **Part D Grievances** in Section 1 of this booklet. We will try to resolve your complaint over the phone. If you ask for a written response, 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 FreedomBlue PFFS Grievance Procedure.**

The FreedomBlue PFFS Expedited Grievance Procedure is as follows:

The expedited grievance procedure is used in the following instances:

- If you disagree with the decision made by Highmark Blue Shield not to grant you an expedited initial determination or reconsideration.
- If you disagree with Highmark Blue Shield invoking a 14-day extension on either an initial determination or a reconsideration (Part C only).

Your initial inquiry should be directed to the FreedomBlue PFFS Member Service department. Please refer to the phone numbers in the introduction.

- You may file this request either orally or in writing. Your complaint may include information from you or any other party of interest.
- Highmark Blue Shield will review your complaint and take the appropriate steps to investigate your complaint. Highmark Blue Shield will respond in writing within 24 hours from the date the FreedomBlue PFFS Grievance Department receives your complaint.

The FreedomBlue PFFS Standard Grievance Procedure is as follows:

- Your initial inquiry should be directed to the FreedomBlue PFFS Member Service department. If you are dissatisfied with the response to your inquiry, you can ask for a First Level Complaint Review. Your complaint for review should be made in writing. Your written complaint may include written information from you or any other party of interest. Accommodations will be made for those members who cannot submit their requests in writing.

  Send your written complaint to:

  FreedomBlue PFFS Appeals and Grievance Department
  P.O. Box 535047
  Pittsburgh, PA 15253-5047
  Fax # 1-412-544-1513

- Highmark Blue Shield will review your written complaint. For complaints regarding such issues as waiting times, physician or pharmacy staff behavior and demeanor, quality of care, adequacy of or access to facilities, fraud or abuse concerns, and other similar member concerns, Highmark Blue Shield will take the appropriate steps to investigate your complaint. These steps may include, but are not limited to, investigating with the provider, a review of the medical records or ongoing provider monitoring. Highmark Blue Shield will respond in writing within 30 calendar days or as expeditiously as the case requires.
- Complaints that do not involve providers or general dissatisfaction with the plan will be forwarded to the First Level Complaint Committee for review. Examples of such complaints may include, but are not limited to, involuntary disenrollment situations or requests for premium reimbursement. You will receive a response from the First Level Complaint Committee in writing within 30 calendar days or as expeditiously as the case requires. If you are dissatisfied with the response to your complaint, you may request to have the decision reviewed by a Second Level Complaint Committee. The request to have the decision reviewed must be submitted in writing within 45 calendar days from the date the decision is received and may include any written supporting material from you or any party of interest.

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- The Second Level Complaint Committee is comprised of three individuals who did not participate in the initial reviews. At least one Committee member will not be a Highmark employee, but they must be a member of a Highmark health care plan. The Committee will hold an informal hearing to consider your complaint. When arranging the hearing, Highmark Blue Shield will notify you in writing of the hearing procedures and your rights at the hearing, including your right to appear before the Committee. The hearing will be held within 30 calendar days of the Committee's receipt of your request for review. The Committee will provide written notification of the decision within five business days of the hearing. The notification will specify the reasons for the decision.
- The decision of the Second Level Complaint Committee will be binding.
- For further information regarding the purposes and operations of the grievance procedure, contact FreedomBlue PFFS Member Service.

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.

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 an independent review organization called the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

How to File a Quality of Care Complaint with the QIO

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See Section 1 for more information about how to file a quality of care complaint with the QIO.

9 What to Do if You Have Complaints about Your Part C Medical Services and Benefits

Introduction

This section gives the rules for making complaints about Part C services and payments in different types of situations. **Note: Please see Section 10 for complaints about prescription drugs (Part D).** Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

Please refer to Original Medicare of your 2008 *Medicare & You* handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare & You* handbook, please call 1-800-MEDICARE (1-800-633-4227) to get a copy.

How to Make Complaints in Different Situations

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

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.

If you want to make a complaint about any situation not listed above, you may file a **grievance. For more information about grievances, see Section 8.**

PART 1. Complaints about what benefit or service the Plan will approve or what the Plan will pay for

What Are "Complaints about Your Services or Payment for Your Care?"

- If you are not getting the care you want, and you believe that this care is covered by the Plan.
- If 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.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not medically necessary or is not a plan benefit.

What Is an Organization Determination?

An organization determination is our **initial decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our initial decision is to deny your request, you may **appeal** the decision by going to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

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When we make an "organization determination," we are giving our interpretation of how the benefits and services that are covered for members of the Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by the Plan, including any limits on these services. This booklet also lists services that are "not covered" by the Plan.

Who May Ask for an "Organization Determination" about Your Medical Care or Payment?

Your doctor or other medical provider may ask us whether we will approve the treatment. You may also ask us for an initial decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone 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, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under **Part C Organization Determinations** in **Section 1** of this booklet. Please call us at the phone number shown under **Part C Organization Determinations** for more information. You also have the right to have a lawyer act for you. You can get your own lawyer, or find 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. You may want to call the Pennsylvania SeniorLAW Helpline at 1-877-727-7529.

Do You Have a Request for Medical Care that Needs to Be Decided More Quickly than the Standard Time Frame?

A decision about whether we will pay for or approve medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is also called an "expedited organization determination." You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a Standard Decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request *in writing* to the address listed under **Part C Organization Determinations** in **Section 1** of this booklet.

Asking for a Fast Decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us. Or you may send or fax us a written request to the fax number or address listed under **Part C Organization Determinations** in Section 1 of this booklet. For oral requests and for requests made outside of regular business hours, call 1-800-485-9610. TTY users call 1-888-422-1226. Be sure to ask for a "fast" or "72-hour" review.

If **any** 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 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 you don't need a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 8.

What Happens Next When You Request an Initial Decision?

1. For a decision about payment for care you already received.

   We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can appeal this decision. If you have not received an answer from us within 60 days of your request, you can **appeal** this decision. (An appeal is also called a "reconsideration.")

2. For a *standard* decision about medical care.

   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". If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision. 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.

3. For a *fast* decision about medical care.

   If you receive a "fast" decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it—sooner if your health requires. 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 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 deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request and you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1:
If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us if you need help in filing your appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a "fast" appeal. The procedures for deciding on a "standard" or a "fast" appeal are the same as those described for a "standard" or "fast" initial decision. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Please refer to Section 1 of this booklet for addresses and phone numbers for filing an appeal.

Getting Information to Support Your Appeal

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

You can give us additional information to support your appeal by calling, faxing, or writing to the numbers or address listed under **Part C Appeals** in **Section 1** of this booklet. You can also deliver additional information in person to the address listed under **Part C Appeals** in **Section 1** of this booklet. You also have the right to ask us for a copy of the information we have regarding your appeal. You may call or write us at the numbers or address listed under **Part C Appeals** in **Section 1** of this booklet.

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How Do You File Your Appeal of the Organization Determination?

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 'Organization Determination' about Medical Care or Payment?" However, providers who do not have a contract with the Plan must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the appeal.

How Soon Must You File Your Appeal?

You must file your appeal within 60 days after we notify you of our decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal, you may call or write us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet.

What if You Want a "Fast" Appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" decision. While the process for deciding on a fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Please refer to Section 1 of this booklet for addresses and phone numbers for filing a fast or expedited appeal.

How Soon Must We Decide on Your Appeal?

1. For a decision about *payment* for care you already received.

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

2. For a *standard* decision about *medical care*.

   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.

3. For a *fast* decision about *medical care*.

   After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health 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 Next if We Rule Completely in Your Favor?

1. For a decision about *payment* for care you already received.

   We must pay within 60 days of the day we received your appeal.

2. For a *standard* decision about *medical care*.

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

3. For a *fast* decision about *medical care*.

   We must authorize or provide your requested care within 72 hours of receiving your appeal—or sooner, if your health requires it. If we extended the time needed to decide your appeal, we will authorize or provide your medical care immediately.

Appeal Level 2: If on your Level 1 appeal, we do not rule completely in your favor, your appeal will automatically be reviewed by an independent review entity

If we do not rule completely in your favor, your appeal is automatically sent to Appeal Level 2 where an independent review entity that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program, and is not part of the Plan, will review your appeal. We will tell you in writing that your appeal has been sent to this organization for review. How quickly we must forward your appeal depends on the type of appeal:

1. For a decision about *payment* for care you already received.

   We must forward your appeal to the independent review entity within 60 days of the date we received your Level 1 appeal.

2. For a *standard* decision about *medical care*.
   We must forward your appeal to the independent review entity as quickly as your health requires, but no later than 30 days after we received your Level 1 appeal.

3. For a *fast* decision about *medical care*.

   We must forward your appeal to the independent review entity within 24 hours of our decision.

We will send the independent review entity a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under **Part C Appeals** in Section 1 of this booklet.

How Soon Must the Independent Review Entity Decide?

1. For an appeal about *payment* for care, the independent review entity has 60 days to make a decision.
2. For a *standard* appeal about *medical care*, the independent review entity has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.
3. For a *fast* appeal about *medical care*, the independent review entity has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

If the Independent Review Entity Decides Completely in Your Favor

The independent review entity will tell you in writing about its decision.

1. For an appeal about *payment* for care.

   We must pay within 30 days after receiving the decision.

2. For a *standard* appeal about *medical care*.

   We must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

   We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the service area, we must authorize the services within 72 hours from the date we receive notice that the independent review entity reversed the determination.

3. For a *fast* appeal about *medical care*.

   We must authorize or provide the care you requested within 72 hours after receiving the decision.

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Appeal Level 3: If the entity that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement included in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How Soon Will the Judge Make a Decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

If the Judge Decides in Your Favor

We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How Soon Will the Council Make a Decision?

If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

If the Council Decides in Your Favor

We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

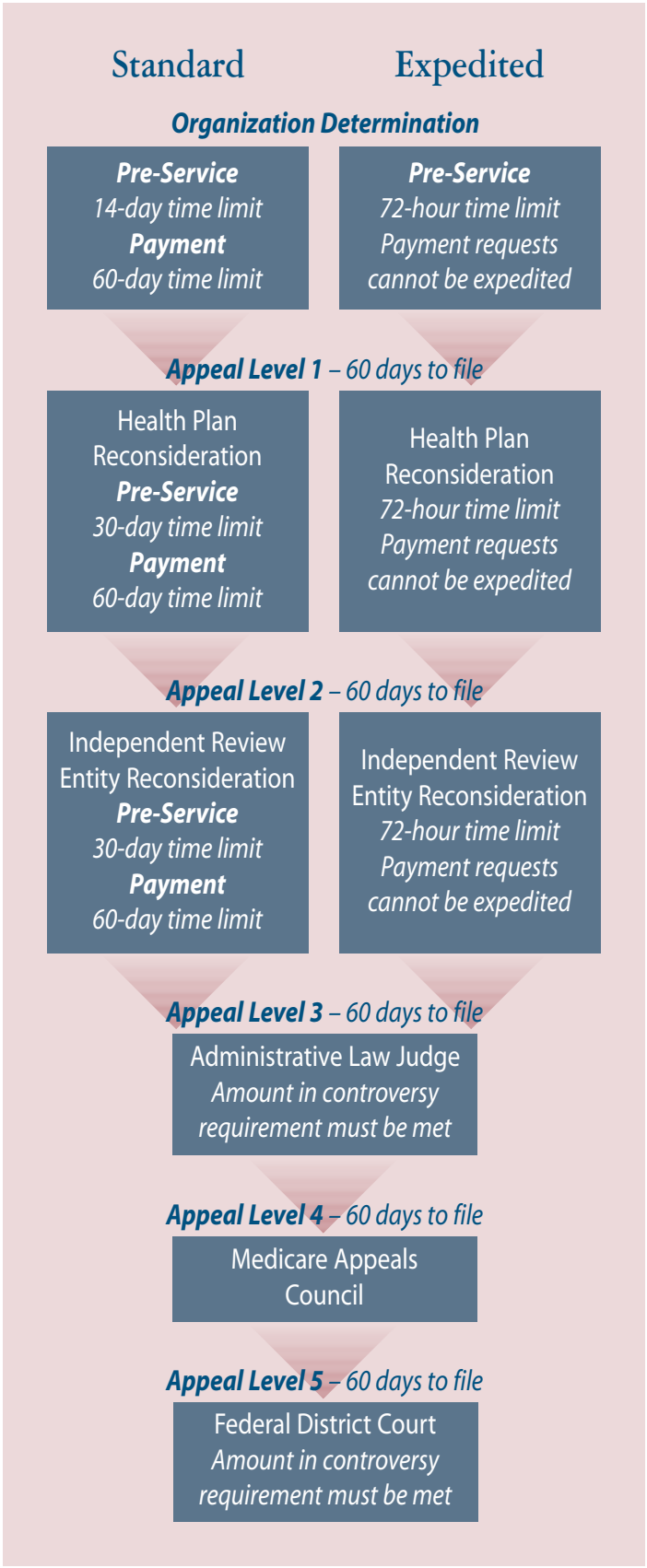
Appeal Level 5: If the Medicare Appeal Council does not rule completely in your favor, you may ask for a review by a Federal Court

You may file an appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How Soon Will the Judge Make a Decision?

The Federal judiciary controls the timing of any decision. The Judge's decision is final.

Complaint process for what benefit or service the Plan will approve or what the Plan will pay for:



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

9

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, someone at the hospital must give you a notice called the Important Message from Medicare (call our Plan Member Service phone number listed in **Section 1** 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 two 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.

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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. 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 from Medicare patients who think their hospital stay is ending too soon. The QIO for Pennsylvania is:

Quality Insights of Pennsylvania
2601 Market Place Street, Suite 320
Harrisburg, PA 17110
1-877-346-6180

Getting QIO Review of Your Hospital Discharge

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

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from the QIO 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 the QIO.**
- The QIO will look at your medical information provided to the QIO by us and the hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO 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 the QIO Decides in Your Favor?

We will continue to cover your hospital stay for as long as it is medically necessary (except for any applicable copayments or deductibles).

What Happens if the QIO Agrees with the Discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO 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 the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after the QIO gave you its first decision.

What Happens if You Appeal the QIO Decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO 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 as long as it is medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (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 (Administrative Law Judge, Medicare Appeal Council, Federal Court) 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 as long as it is medically necessary (except for any applicable copayments or deductibles).

What if You Do Not Ask the QIO for a Review by the Deadline?

If you do not ask the QIO 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 for as long as it is medically necessary (except for any applicable copayments or deductibles).
- 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 organization within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Organization (IRO) appeal. If the IRO 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 (Independent Review Organization, Administrative Law Judge, Medicare Appeal Council, Federal Court) 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 as long as they are medically necessary (except for any applicable copayments or deductibles).

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 two days before coverage for your services ends (call the Plan Member Service phone number in **Section 1** 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.**

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Getting QIO 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") 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 QIO Review?

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

- If you get the notice two days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than two 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 the QIO's Review?

The QIO 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. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. 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 the Plan Member Service phone number in Section 1 or 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives all the information it needs.

What Happens if the QIO Decides in Your Favor?

We will continue to cover your SNF, HHA or CORF services for as long as they are medically necessary (except for any applicable copayments or deductibles).

What Happens if the QIO 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 the QIO to review its first decision if you make the request within 60 days of receiving the QIOs first denial of your request.

What Happens if You Appeal the QIO Decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO 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 as long as they are medically necessary (except for any applicable copayments or deductibles).

If the QIO upholds its original decision, you may be able to appeal its decision to the 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 or a Federal Court. If either the Medicare Appeal Council 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 as long as they are medically necessary (except for any applicable copayments or deductibles).

What if You Do Not Ask the QIO for a Review by the Deadline?

If you do not ask the QIO 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 you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary (except for any applicable co-payments or deductibles).
- 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 within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Entity (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 (Independent Review Entity, Administrative Law Judge, Medicare Appeal Council, Federal Court) 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 as long as they are medically necessary (except for any applicable copayments or deductibles).

10 What to Do if You Have Complaints about Your Part D Prescription Drug Benefits

What to Do if You Have Complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Member Service at the number in Section 1 of this booklet.

Please note that this section addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Section 9.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with us or one of our network pharmacies that does not relate to coverage for a prescription drug. For more information about grievances, see Section 8.

A coverage determination is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a coverage determination. For more information about coverage determinations and exceptions, see the section "How to Request a Coverage Determination" below.

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. You cannot request an appeal if we have not issued a coverage determination. If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section "The Appeal Process" below.

How to Request a Coverage Determination

What Is the Purpose of this Section?

This part of Section 10 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What Is a Coverage Determination?

The coverage determination we make is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact us and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you may "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage-determination requests:

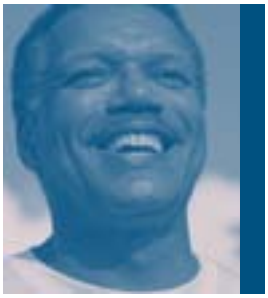
- You ask us to pay for a prescription drug you have received. This is a request for a coverage determination about payment. You may call us at the phone number shown under **Part D Coverage Determinations** in **Section 1** of this booklet to ask for this type of decision.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You may call us at the phone number shown under **Part D Coverage Determination**s in Section 1 of this booklet to ask for this type of decision. **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, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **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." You may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to ask for this type of decision. **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 may call us at the phone number shown under **Part D Coverage Determinations** in Section 1 of this booklet to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

What Is an Exception?

An exception is a type of coverage determination. You may ask us to make an exception to our coverage rules in a number of situations.

- You may ask us to cover your 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 drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. **See Section 4 ("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 drug. If your drug is contained in our non-preferred tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the copayment amount you must pay for your drug. Please note, if we grant your request to cover a 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 drugs that are in the Specialty tier.

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



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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 drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you may appeal our decision.

Who May Ask for a Coverage Determination?

You, your prescribing physician, or someone you name may ask us for a coverage 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, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under **Part D Coverage Determinations** in Section 1 of this booklet. To learn how to name your appointed representative, you may call Member Service at the number in Section 1 of this booklet.

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" Coverage Determination

Do You Have a Request for a Part D Prescription Drug that Needs to Be Decided More Quickly than the Standard Time Frame?

A decision about whether we will give you or pay for a Part D prescription drug can be a "standard" coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is also called an "expedited coverage determination."

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 Part D drugs that you have not received yet. You cannot get a fast decision if you are asking us to pay you back for a Part D drug that you already received.)

Asking for a Standard Decision

To ask for a standard decision, you, your doctor, or your appointed representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** in Section 1 of this booklet. For requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), please call 1-866-675-8634 or the Member Service number on your FreedomBlue PFFS identification card and select prompt 5.

Asking for a Fast Decision

You, your doctor, or your appointed 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** in Section 1 of this booklet. For requests made outside of regular business hours (Monday through Sunday, 8:00 a.m. to 8:00 p.m.), please call 1-866-675-8634 or the Member Service number on your FreedomBlue PFFS identification card and select prompt 5. Be sure to ask for a "fast," "expedited," or "24-hour" 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 coverage determination 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 coverage determination, 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 "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard time frame.

What Happens When You Request a Coverage Determination?

1. For a *standard* coverage determination about a Part D drug that includes 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 health condition requires. 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 dosage or 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, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a *fast* coverage determination about a Part D drug that you have not 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—sooner if your health requires. 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 non-formulary or non-preferred 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, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What Happens if We Decide Completely in Your Favor?

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

   We must give you 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 give you 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.

2. For a *fast* decision about a Part D drug that you have not received.

   We must give you 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 give you the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

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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 a coverage determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

The Appeals Process

This part of Section 10 explains what you can do if you disagree with our coverage determination.

What Kinds of Decisions Can Be Appealed?

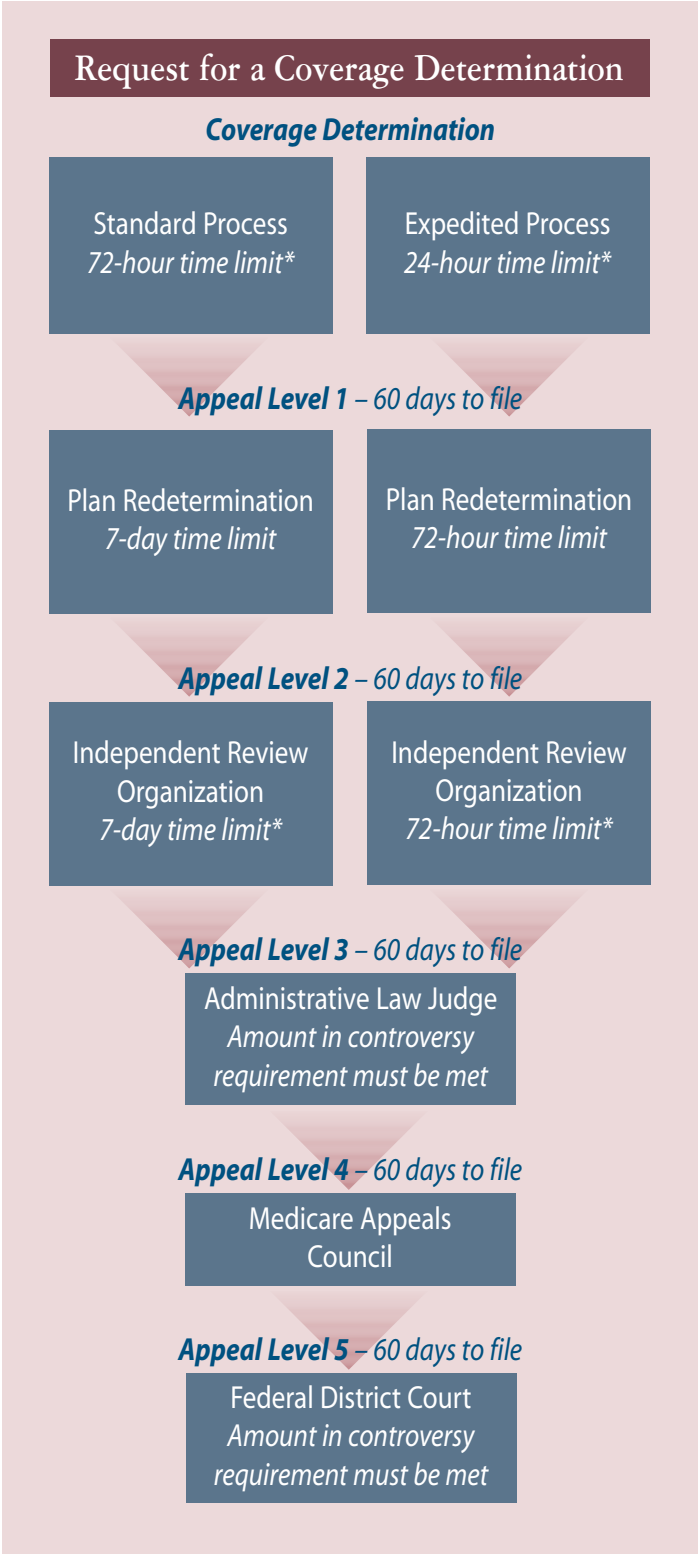
If you are not satisfied with our coverage determination decision, you may ask for an appeal called a "redetermination." You may generally appeal the following decisions:

- We do not cover a Part D drug you think you are entitled to receive,
- We do not pay you back for a Part D drug that you paid for,
- We paid you less for a Part D drug than you think we should have paid you,
- We ask you to pay a higher copayment amount than you think you are required to pay for a Part D drug, or
- We deny your exception request.

How Does the Appeals Process Work?

There are five levels in the appeals process. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to appeal it and have someone else review your request.

The following chart summarizes the appeals process. Each appeal level is discussed in greater detail below.



* The adjudication time frames generally begin when the request is received by the Plan sponsor. However, if the request involves an exception to the Plan's formulary, the adjudication time frame begins when the Plan sponsor or independent review organization receives the doctor's supporting statement.

Appeal Level 1:
If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our coverage determination, even if only part of our decision is not what you requested. When we receive your request to review the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

Who May File Your Appeal of the Coverage Determination?

You or *your appointed representative* may file a **standard appeal** request.

You, *your appointed representative*, or *your doctor* may file a **fast appeal** request.

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 coverage 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, you or your appointed representative may send a *written* appeal request to the address listed under **Part D Appeals** in Section 1 of this booklet.
2. **Asking for a fast appeal**
   If you are appealing a decision we made about giving you a Part D drug 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 coverage determination. You, your doctor, or your appointed representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** in **Section 1** of this booklet. Be sure to ask for a "fast," "expedited," or "72-hour" 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. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent is different. Please refer to Section 1 of this booklet for addresses and phone numbers for filing an appeal.

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. 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** in Section 1 of this booklet. You may also deliver additional information in person to the address listed under **Part D Appeals** in Section 1 of this booklet. 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** in Section 1 of this booklet.

How Soon Must We Decide on Your Appeal?

1. 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 your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

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2. For a *fast* decision about a *Part D drug that you have not 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 requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What Happens if We Decide Completely in Your Favor?

1. For a *standard* decision to pay you back for a *Part D drug you already paid for and received*.

   We must send payment to you no later than 30 calendar days after we receive your appeal request.

2. For a *standard* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within seven calendar days we receive your appeal request. We will give it to you sooner if your health requires us to.

3. For a *fast* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 72 hours after we receive your appeal request. We will give it to you sooner if your health requires us to.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What Independent Review Organization Does this Review?

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

Who May File Your Appeal?

You or *your appointed representative* may file a **standard** or **fast** appeal request.

How Soon Must You File Your Appeal?

You must file the appeal request within *60 calendar days* after the date you were notified of the decision on your first appeal. The independent review organization 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, you or your appointed representative can send a *written* appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. **Asking for a fast appeal**
   To ask for a fast appeal, you or your appointed representative may send a *written* appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically give you a fast appeal.

How Soon Must the Independent Review Organization Decide?

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

   The independent review organization will give you its decision within seven calendar days after they receive your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

2. For a *fast* decision about a *Part D drug that you have not received*.

   The independent review organization will give you its decision within 72 hours after they receive your appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an exception to the Plan's formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the Independent Review Organization Decides Completely in Your Favor

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

1. 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 coverage determination.

2. For a *standard* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a *fast* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 3:
If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

If the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the independent review organization's decision. During the Administrative Law Judge 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.

Who May File Your Appeal?

You or *your appointed representative* may file an appeal request with an Administrative Law Judge.

How Soon Must You File Your Appeal?

The appeal request must be filed within *60 calendar days* of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to File Your Appeal

The request must be filed with an Administrative Law Judge *in writing*. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your appeal if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How Is the Dollar Value (the "Amount Remaining in Controversy") Calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year,
- Your copayments,
- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

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You May also Combine Multiple Part D Claims to Meet the Dollar Value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed *in writing* within *60 calendar days* after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How Soon Will the Judge Make a Decision?

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

If the Judge Decides in Your Favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a *standard* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a *fast* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 4: If an Administrative Law Judge does not rule in your favor, your case may be reviewed by the Medicare Appeals Council

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who May File Your Appeal?

You or *your appointed representative* may request an appeal with the Medicare Appeals Council.

How Soon Must You File Your Appeal?

The appeal request must be filed within *60 calendar days* after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How to File Your Appeal

The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this appeal.

How Soon Will the Council Make a Decision?

The Medicare Appeals Council will first decide whether to review your case (it does not review every case it receives). If the Medicare Appeals Council 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 Medicare Appeals Council 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

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a *fast* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5: If the Medicare Appeals Council does not rule in your favor, your case may go to a 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 Medicare Appeals Council decided not to review your appeal request.

Who May File Your Appeal?

You or *your appointed representative* may request an appeal with a Federal Court.

How Soon Must You File Your Appeal?

The appeal request must be filed within *60 calendar days* after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

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. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug(s) does not meet the minimum requirement specified in the Medicare Appeals Council'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

1. For a decision to pay you back for a Part D drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

2. For a *standard* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a *fast* decision about a *Part D drug you have not received*.

   We must give you the Part D drug you asked for within 24 hours after we receive notice reversing our coverage determination.

If the Judge Decides Against You

The Judge's decision is final and you may not take the appeal any further.

11 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

In general, there are only certain times during the year when you may voluntarily end your membership in our Plan.

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the *Medicare & You* handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

Until Your Membership Ends, You Must Keep Getting Your Medicare Services through Our Plan or You Will Have to Pay for Them Yourself

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 or through 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 health 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, seven days a week.

Involuntarily Ending Your Membership

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

- **If you move out of the service area or are away from the service area for more than six months in a row**. If you plan to move or take a long trip, please call Member Service to find out if the place you are moving to or traveling to is in our Plan's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row, you cannot remain a member of our Plan. In these situations, if you do not leave on your own, we must end your membership ("disenroll" you).
- If you do *not* stay continuously enrolled in Medicare A and B.
- If you give us information on your enrollment request that your know is false or deliberately misleading, and it affects whether or not you can 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.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60-day grace period during which you may pay the Plan premiums before your membership ends.

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.

12 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 of Pennsylvania may apply.

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 or Medicare Prescription Drug 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.

13 Definitions of Some Words Used in this Book

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 or payment for services 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 Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Part D Plan Sponsor must use when you ask for an appeal. Sections 9 and 10 explain about 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 you actually get during the stay determines whether you are considered an inpatient for SNF stays, but not for hospital stays.

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. (Section 7 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are getting inpatient services in the hospital (the type of care you actually receive in the hospital doesn't determine whether you are considered an inpatient in the hospital).

Brand Name Drug—A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage—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 $4,050 in covered drugs during the covered year. Please see Section 4 of this document.

Centers for Medicare & Medicaid Services (CMS)—The Federal agency that runs the Medicare program. Section 1 explains how to contact CMS.

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

Coverage Determination—The Plan has made a coverage determination when it makes a decision about the benefits you can receive under the Plan, and the amount that you must pay for those benefits.

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

Covered Services—The general term we use in this booklet to mean all of the health care services and supplies that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 3.

Creditable Coverage—Coverage that is at least as good as the standard Medicare prescription drug coverage.

Disenroll or Disenrollment—The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about disenrollment.

Durable Medical Equipment—Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen.

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. Section 2 tells about emergency services.

Evidence of Coverage and Disclosure Information—This document along with your enrollment form, which explains your coverage, and what we must do, and explains 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).

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

Generic Drug—A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

Grievance—A type of complaint you make about us or one of our Plan providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve payment or coverage disputes. See Section 8 for more information about grievances.

Initial Coverage Period—This is the period after you have met your deductible (if you have one) and before your total drug expenses, have reached $2,510 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 don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have creditable prescription drug coverage, you will have to pay a penalty in addition to your monthly plan premium.

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 permanent kidney failure (who need dialysis or a kidney transplant).

Medicare Advantage Organization—Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Part C." They provide all your Part A (Hospital) and Part B (Medical) coverage. Some may also provide Part D (prescription drug) coverage.

Medicare Advantage Plan—A benefit package offered by a Medicare Advantage Organization that 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. We are a Medicare Advantage Organization.

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Medicare Prescription Drug Coverage—Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare 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.

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

Member Service—A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Service.

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.

Organization Determination—The MA 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—Some people call it "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 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 services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 2.

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 and barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (Section 7 for a listing of these drugs). These drugs are not considered Part D drugs.

Prior Authorization—Approval in advance to get services. In a PPO and PFFS plan you do not need prior authorization to obtain out-of-network services. However, you may want to check with your plan before obtaining services out of network to confirm that the service is covered by your plan and what your cost share responsibility is. If your plan offers Part D drugs, certain drugs may require prior authorization. Check with your plan.

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 1 for information about how to contact the QIO in your state and Section 9 for information about making complaints to the QIO.

Quantity Limits—A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Rehabilitation Services—These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider.

Service Area—Section 1 tells about our Plan's 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 Medicare Health Plan.

Urgently Needed Care—Section 2 explains urgently needed services. These are different from emergency services.

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HIGHMARK.
FREEDOMBLUE PFFS
A Medicare Advantage Private Fee-for-Service Program

Highmark Blue Shield is a health plan with a Medicare contract with the Federal government. This contract is renewed annually and the availability of coverage beyond the end of the current contract year is not guaranteed.

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