

January 1 – December 31, 2013

Evidence of Coverage:

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Medicare HMO Blue PlusRx (HMO)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 – December 31, 2013. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

This plan, Medicare HMO Blue PlusRx, is offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. When it says “plan” or “our plan,” it means Medicare HMO Blue PlusRx.)

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. is a Medicare Advantage organization with a Medicare contract.

Member Service has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

This information is available in alternate formats such as large print.

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2014.



MASSACHUSETTS

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2013 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1. Getting started as a member..... 1

Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, your plan premium, your plan membership card, and keeping your membership record up to date.

Chapter 2. Important phone numbers and resources 14

Tells you how to get in touch with our plan (Medicare HMO Blue PlusRx) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

Chapter 3. Using the plan's coverage for your medical services..... 31

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in the plan's network and how to get care when you have an emergency.

Chapter 4. Medical Benefits Chart (what is covered and what you pay) 44

Gives the details about which types of medical care are covered and *not* covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.

Chapter 5. Using the plan's coverage for your Part D prescription drugs 75

Explains rules you need to follow when you get your Part D drugs. Tells how to use the plan's *List of Covered Drugs (Formulary)* to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to coverage for certain drugs. Explains where to get your prescriptions filled. Tells about the plan's programs for drug safety and managing medications.

Chapter 6. What you pay for your Part D prescription drugs 93

Tells about the four stages of drug coverage (*Deductible Stage, Initial Coverage Stage, Coverage Gap Stage, Catastrophic Coverage Stage*) and how these stages affect what you pay for your drugs. Explains the five cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each cost-sharing tier. Tells about the late enrollment penalty.

Chapter 7. Asking us to pay our share of a bill you have received for covered medical services or drugs 111

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

Chapter 8. Your rights and responsibilities 117

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

Chapter 9. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)..... 126

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

- Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.
- Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

Chapter 10. Ending your membership in the plan 176

Explains when and how you can end your membership in the plan. Explains situations in which our plan is required to end your membership.

Chapter 11. Legal notices 184

Includes notices about governing law and about nondiscrimination.

Chapter 12. Definitions of important words 189

Explains key terms used in this booklet.

Chapter 1. Getting started as a member

SECTION 1	Introduction	3
Section 1.1	You are enrolled in Medicare HMO Blue PlusRx, which is a Medicare HMO	3
Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?	3
Section 1.3	What does this Chapter tell you?	3
Section 1.4	What if you are new to Medicare HMO Blue PlusRx?	3
Section 1.5	Legal information about the <i>Evidence of Coverage</i>	4
SECTION 2	What makes you eligible to be a plan member?.....	4
Section 2.1	Your eligibility requirements	4
Section 2.2	What are Medicare Part A and Medicare Part B?.....	4
Section 2.3	Here is the plan service area for Medicare HMO Blue PlusRx	5
SECTION 3	What other materials will you get from us?.....	5
Section 3.1	Your plan membership card – Use it to get all covered care and prescription drugs.....	5
Section 3.2	The <i>Provider Directory</i> : Your guide to all providers in the plan’s network	6
Section 3.3	The <i>Pharmacy Directory</i> : Your guide to pharmacies in our network	6
Section 3.4	The plan’s <i>List of Covered Drugs (Formulary)</i>	7
Section 3.5	The <i>Explanation of Benefits</i> (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs	7
SECTION 4	Your monthly premium for Medicare HMO Blue PlusRx	7
Section 4.1	How much is your plan premium?.....	7
Section 4.2	There are several ways you can pay your plan premium.....	9
Section 4.3	Can we change your monthly plan premium during the year?	10

SECTION 5	Please keep your plan membership record up to date	11
Section 5.1	How to help make sure that we have accurate information about you	11
SECTION 6	We protect the privacy of your personal health information.....	12
Section 6.1	We make sure that your health information is protected	12
SECTION 7	How other insurance works with our plan	12
Section 7.1	Which plan pays first when you have other insurance?.....	12

SECTION 1 Introduction

Section 1.1	You are enrolled in Medicare HMO Blue PlusRx, which is a Medicare HMO
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You are covered by Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Medicare HMO Blue PlusRx.

There are different types of Medicare health plans. Medicare HMO Blue PlusRx is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

Section 1.2	What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs covered through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Medicare HMO Blue PlusRx is offered by Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. (When this *Evidence of Coverage* says “we,” “us,” or “our,” it means Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. When it says “plan” or “our plan,” it means Medicare HMO Blue PlusRx.)

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs available to you as a member of Medicare HMO Blue PlusRx.

Section 1.3	What does this Chapter tell you?
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Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan’s service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up to date?

Section 1.4	What if you are new to Medicare HMO Blue PlusRx?
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If you are a new member, then it’s important for you to learn what the plan’s rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

If you are confused or concerned or just have a question, please contact our plan’s Member Service (phone numbers are printed on the back cover of this booklet).

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in Medicare HMO Blue PlusRx between January 1, 2013 and December 31, 2013.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you have both Medicare Part A and Medicare Part B
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is the plan service area for Medicare HMO Blue PlusRx

Although Medicare is a Federal program, Medicare HMO Blue PlusRx is available only to individuals who live in our plan service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes these counties in Massachusetts:

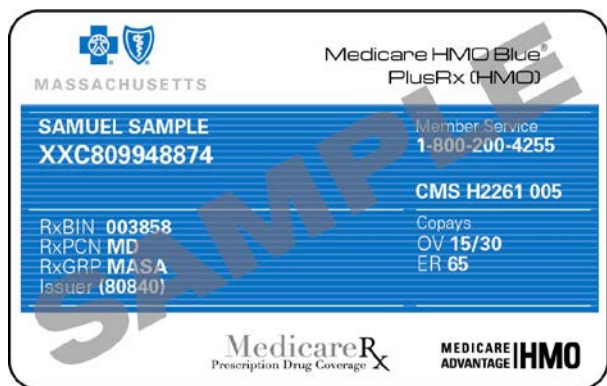
Barnstable County	Hampden County	Plymouth County
Bristol County	Hampshire County	Suffolk County
Essex County	Middlesex County	Worcester County
Franklin County	Norfolk County	

If you plan to move out of the service area, please contact Member Service (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered care and prescription drugs

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



As long as you are a member of our plan **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your Medicare HMO Blue PlusRx membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Member Service right away and we will send you a new card. (Phone numbers for Member Service are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider Directory</i>: Your guide to all providers in the plan's network
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What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which Medicare HMO Blue PlusRx authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Service (phone numbers are printed on the back cover of this booklet). You may ask Member Service for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at www.bluecrossma.com/findadoctor, or download it from this website. Both Member Service and the website can give you the most up-to-date information about changes in our network providers.

Section 3.3	The <i>Pharmacy Directory</i>: Your guide to pharmacies in our network
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What are “network pharmacies”?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Service (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Service to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.bluecrossma.com/medicare-options.

Section 3.4 The plan's *List of Covered Drugs (Formulary)*

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

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

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.bluecrossma.com/formularies/medicare) or call Member Service (phone numbers are printed on the back cover of this booklet).

Section 3.5 The *Explanation of Benefits* (the “EOB”): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the “EOB”).

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Service (phone numbers are printed on the back cover of this booklet).

SECTION 4 Your monthly premium for Medicare HMO Blue PlusRx

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2013, the monthly premium for Medicare HMO Blue PlusRx is \$183.00. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be less

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

If you are *already enrolled* and getting help from one of these programs, **the information about premiums in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs”

(also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Service and ask for the “LIS Rider.” (Phone numbers for Member Service are printed on the back cover of this booklet.)

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. This situation is described below.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) For these members, the late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
 - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 9 explains the late enrollment penalty.
 - If you have a late enrollment penalty and do not pay it, you could be disenrolled from the plan.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, many members are required to pay other Medicare premiums. As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren’t eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of the plan.**

Some people pay an extra amount for Part D because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.**
- If you have to pay an extra amount, Social Security, **not your Medicare plan**, will send you a letter telling you what that extra amount will be.
- For more information about Part D premiums based on income, go to Chapter 6, Section 10 of this booklet. You can also visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2013* gives information about the Medicare premiums in the section called “2013 Medicare Costs.” This explains how the Medicare Part B and Part D premiums differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2013* from the Medicare website <http://www.medicare.gov>. Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 There are several ways you can pay your plan premium

There are three ways you can pay your plan premium. Contact Member Service for information on your payment options and how to change your payment option choice.

If you decide to change the way you pay your premium, it can take up to three months for your new payment method to take effect. While we are processing your request for a new payment method, you are responsible for making sure that your plan premium is paid on time.

Option 1: You can pay by check

You may decide to pay your monthly plan premium directly to our plan. You may choose to pay with a check or money order. Our plan premium is due on or before the first of each month. We will send you a bill every month for the plan premium you owe to us. The bill will tell you the amount of your monthly plan premium and the date your plan premium is due. The bill will also tell you where to send your payment: Blue Cross Blue Shield of Massachusetts, P.O. Box 371314, Pittsburgh, PA 15250-7314. Checks should be made payable to Blue Cross Blue Shield of Massachusetts.

Option 2: You can have the plan premium automatically withdrawn from your bank account

Instead of paying by check, you can have your monthly plan premium automatically withdrawn from your bank account. This is called “electronic fund transfer.” If you enroll to pay by electronic fund transfer, you will not receive any more bills from us. Your plan premium will be automatically deducted from your bank account on the billing due date (or the next banking day for holidays) on a monthly basis. If there is a plan premium change, the new amount will be automatically deducted from your bank account. We will notify you in writing of any change. If your bank account has insufficient funds on your premium due date, we will be unable to collect your plan premium from your bank account and your account with us will become delinquent. If this happens we will notify you, and your electronic payment service will be discontinued, and all future bills will be sent to you on paper.

Option 3: You can have the plan premium taken out of your monthly Social Security check

You can have the plan premium taken out of your monthly Social Security check. Contact Member Service for more information on how to pay your plan premium this way. We will be happy to help you set this up. (Phone numbers for Member Service are printed on the back cover of this booklet.)

What to do if you are having trouble paying your plan premium

Your plan premium is due in our office by the first day of the month. If we have not received your premium payment by the first of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium within two calendar months.

If you are having trouble paying your premium on time, please contact Member Service to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Service are printed on the back cover of this booklet.)

If we end your membership with the plan because you did not pay your plan premium, then you may not be able to receive Part D coverage until the following year if you enroll in a new plan during the annual enrollment period. During the annual enrollment period, you may either join a stand-alone prescription drug plan or a health plan that also provides drug coverage. (If you go without “creditable” drug coverage for more than 63 days, you may have to pay a late enrollment penalty for as long as you have Part D coverage.)

If we end your membership because you did not pay your premium, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. We have the right to pursue collection of the premiums you owe. *AND/OR* In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the amount you owe before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 9, Section 10 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask Medicare to reconsider this decision by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 4.3 Can we change your monthly plan premium during the year?

No. We are not allowed to change the amount we charge for the plan’s monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

However, in some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member’s monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less towards their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the Extra Help program in Chapter 2, Section 7.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group/IPA.

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

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If you receive care in an out-of-area or out-of-network hospital or emergency room
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

If any of this information changes, please let us know by calling Member Service (phone numbers are printed on the back cover of this booklet).

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Service (phone numbers are printed on the back cover of this booklet).

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4 of this booklet.

SECTION 7 How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?
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When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the “primary payer” and pays up to the limits of its coverage. The one that pays second, called the “secondary payer,” only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member’s current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):
 - If you’re under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
 - If you’re over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers’ compensation

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Service (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

SECTION 1	Medicare HMO Blue PlusRx contacts (how to contact us, including how to reach Member Service at the plan).....	15
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program).....	23
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	24
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare).....	25
SECTION 5	Social Security	26
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	26
SECTION 7	Information about programs to help people pay for their prescription drugs	27
SECTION 8	How to contact the Railroad Retirement Board	30
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	30

SECTION 1 Medicare HMO Blue PlusRx contacts (how to contact us, including how to reach Member Service at the plan)

How to contact our plan's Member Service

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

Member Service	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Service also has free language interpreter services available for non-English speakers.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Member Service P.O. Box 55007 Boston, MA 02205
WEBSITE	www.bluecrossma.com/medicare-options

How to contact us when you are asking for a coverage decision about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For more information on asking for coverage decisions about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

You may call us if you have questions about our coverage decision process.

Coverage Decisions for Medical Care	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	For emergency inpatient acute hospital admissions: 1-866-577-9678. For all other requests: 1-800-477-2994. Calls to these numbers are free.
WRITE	Blue Cross Blue Shield of Massachusetts Member Service P.O. Box 55007 Boston, MA 02205
WEBSITE	www.bluecrossma.com/medicare-options

How to contact us when you are making an appeal about your medical care

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals for Medical Care	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Medicare Advantage Appeals Coordinator P.O. Box 55007 Boston, MA 02205
WEBSITE	www.bluecrossma.com/medicare-options

How to contact us when you are making a complaint about your medical care

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your medical care, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Medical Care	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Medicare Advantage Grievance Coordinator P.O. Box 55007 Boston, MA 02205
MEDICARE WEBSITE	You can submit a complaint about Medicare HMO Blue PlusRx directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx .

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Medicare Advantage Appeals Coordinator P.O. Box 55007 Boston, MA 02205 Or, you can email us at MedicareadvantageRxappeals@bcbsma.com
WEBSITE	www.bluecrossma.com/medicare-options

How to contact us when you are making an appeal about your Part D prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Appeals for Part D Prescription Drugs	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Medicare Advantage Appeals Coordinator P.O. Box 55007 Boston, MA 02205 Or, you can email us at MedicareadvantageRxappeals@bcbsma.com
WEBSITE	www.bluecrossma.com/medicare-options

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).

Complaints about Part D prescription drugs	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Medicare Advantage Grievance Coordinator P.O. Box 55007 Boston, MA 02205
MEDICARE WEBSITE	You can submit a complaint about Medicare HMO Blue PlusRx directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7 (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).

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

Payment Requests	
CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Member Service P.O. Box 55007 Boston, MA 02205
WEBSITE	www.bluecrossma.com/medicare-options

SECTION 2 Medicare

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

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Advantage organizations including us.

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none">• Medicare Eligibility Tool: Provides Medicare eligibility status information.• Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints

you have about Medicare HMO Blue PlusRx:

- **Tell Medicare about your complaint:** You can submit a complaint about Medicare HMO Blue PlusRx directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In Massachusetts the SHIP is called SHINE.

SHINE is independent (not connected with any insurance company or health plan). It is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

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

SHINE "Serving the Health Information Needs of Elders" (Massachusetts' SHIP)	
CALL	1-800-243-4636
	Calls to this number are free.
TTY	1-800-872-0166
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

WRITE	SHINE Executive Office of Elder Affairs One Ashburton Place, 5 th floor Boston, MA 02108
WEBSITE	www.mass.gov (then search for SHINE)

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization for each state. For Massachusetts, the Quality Improvement Organization is called Masspro.

Masspro has a group of doctors and other health care professionals who are paid by the Federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Masspro is an independent organization. It is not connected with our plan.

You should contact Masspro in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Masspro (Massachusetts' Quality Improvement Organization)	
CALL	1-781-890-0011 1-800-252-5533 (Calls to this number are free.)
TTY	1-800-439-2370 Calls to this number are free. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Masspro 245 Winter Street Waltham, MA 02451
WEBSITE	www.masspro.org

SECTION 5 Social Security

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

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

Social Security	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These “Medicare Savings Programs” help people with limited income and resources save money each year:

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

To find out more about Medicaid and its programs, contact the MassHealth Customer Service Center. (In Massachusetts, the health insurance you can get through Medicaid is known as “MassHealth.”)

MassHealth Customer Service Center (Massachusetts’ Medicaid program)	
CALL	1-800-841-2900 Calls to this number are free.
TTY	1-800-497-4648 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WRITE	MassHealth Customer Service Center 55 Summer Street Boston, MA 02110
WEBSITE	www.mass.gov (then search for MassHealth)

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

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

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

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

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

- Please contact Member Service for information on acceptable forms of evidence which demonstrate your eligibility for Extra Help.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Service if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand name drugs from manufacturers that have agreed to pay the discount. The plan pays an additional 2.5% and you pay the remaining 47.5% for your brand drugs.

If you reach the coverage gap, we will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. If you reach the coverage gap, the plan pays 21% of the price for generic drugs and you pay the remaining 79% of the price. The coverage for generic drugs works differently than the coverage for brand name drugs. For generic drugs, the amount paid by the plan (21%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Service (phone numbers are printed on the back cover of this booklet).

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. Also, the plan pays 2.5% of the costs of brand drugs in the coverage gap. The 50% discount and the 2.5% paid by the plan is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don't get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs. In Massachusetts, the State Pharmaceutical Assistance Program is Prescription Advantage.

Prescription Advantage (Massachusetts' State Pharmaceutical Assistance Program)	
CALL	1-800-AGE-INFO (1-800-243-4636)
TTY	1-877-610-0241
	This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
	Calls to this number are free.

WRITE	Prescription Advantage P.O. Box 15153 Worcester, MA 01615
WEBSITE	www.mass.gov (then search for “Prescription Advantage”)

SECTION 8 How to contact the Railroad Retirement Board

The Railroad Retirement Board is an independent Federal agency that administers comprehensive benefit programs for the nation’s railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	http://www.rrb.gov

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group, call the employer/union benefits administrator or Member Service if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Service are printed on the back cover of this booklet.)

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

Chapter 3. Using the plan's coverage for your medical services

SECTION 1	Things to know about getting your medical care covered as a member of our plan.....	33
Section 1.1	What are “network providers” and “covered services”?.....	33
Section 1.2	Basic rules for getting your medical care covered by the plan.....	33
SECTION 2	Use providers in the plan's network to get your medical care.....	34
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee your medical care	34
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?.....	35
Section 2.3	How to get care from specialists and other network providers.....	36
SECTION 3	How to get covered services when you have an emergency or urgent need for care.....	37
Section 3.1	Getting care if you have a medical emergency.....	37
Section 3.2	Getting care when you have an urgent need for care.....	38
SECTION 4	What if you are billed directly for the full cost of your covered services?	39
Section 4.1	You can ask us to pay our share of the cost of covered services	39
Section 4.2	If services are not covered by our plan, you must pay the full cost.....	39
SECTION 5	How are your medical services covered when you are in a “clinical research study”?.....	39
Section 5.1	What is a “clinical research study”?	39
Section 5.2	When you participate in a clinical research study, who pays for what?.....	40
SECTION 6	Rules for getting care covered in a “religious non-medical health care institution”	41
Section 6.1	What is a religious non-medical health care institution?.....	41
Section 6.2	What care from a religious non-medical health care institution is covered by our plan?.....	41

SECTION 7 Rules for ownership of durable medical equipment 42

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?42

SECTION 1 Things to know about getting your medical care covered as a member of our plan

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart in the next chapter, Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*).

Section 1.1 What are “network providers” and “covered services”?
--

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **“Providers”** are doctors and other health care professionals licensed by the state to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2 Basic rules for getting your medical care covered by the plan

As a Medicare health plan, Medicare HMO Blue PlusRx must cover all services covered by Original Medicare and must follow Original Medicare’s coverage rules.

Medicare HMO Blue PlusRx will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary.** “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).

- In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
 - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider.
 - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care

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

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

When you become a member of our plan, you must choose a network provider to be your PCP from the list of our plan's network primary care providers. This list includes internal medicine and family practice physicians and nurse practitioners. (The *Provider Directory* for the plan lists our plan's primary care providers.) Your PCP is a network provider who meets state requirements and is trained to give you basic medical care.

You will usually see your PCP first for most of your routine health care needs. Your PCP will provide most of your care and will coordinate or help you arrange the rest of the covered services you get as a member of our plan. "Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a network specialist). In some cases, your PCP (or other network provider) will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

There are only a few types of covered services you may get on your own without contacting your PCP first. These services are listed below in Section 2.2 (*What kinds of medical care can you get without getting approval in advance from your PCP?*).

How do you choose your PCP?

At the time you enroll in our plan, you must choose a PCP from the list of our plan's network primary care providers, and write your selection on your application. For a complete list of PCPs, please refer to our *Provider Directory*. For the most up-to-date listing, you can visit our website at www.bluecrossma.com/findadoctor.

If you need help in choosing a PCP, you may call Member Service. A representative will be able to tell you a provider's specialty, the medical schools he or she attended and if languages other than English are spoken in the office. We will also check to make sure the provider you choose is accepting new patients. If there is a specific hospital you want to use, we will also check whether your PCP is affiliated with this hospital.

Changing your PCP

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

To change your PCP, call Member Service. When you call, be sure to tell Member Service if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Service will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Service will change your membership record to show the name of your new PCP. The change will be made on the date we get your request or on a future date of your choice.

Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?
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You can get services such as those listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Service before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Service are printed on the back cover of this booklet.)

- Routine refractive eye exams from a Davis Vision network provider.
- For members who have diabetes, medically necessary retinal eye exams as long as you get them from a network provider (except Davis Vision network providers who provide covered routine eye exams).
- Hearing exams as long as you get them from a network provider.
- Preventive dental services as long as you get these services from a network provider.
- Removal of impacted teeth that are fully or partially imbedded in the bone as long as you get these services from a network provider.
- Chiropractic services as long as you get these services from a network provider.
- Bone mass measurements (“bone densitometry”) as long as you get these services from a network provider.
- Diabetes self-management training as long as you get these services from a network provider.

Section 2.3 How to get care from specialists and other network providers

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

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

When your PCP thinks that you need specialized treatment, he or she will give you a referral (approval in advance) to see a network specialist or certain other providers. For some types of referrals, your PCP may need to get approval in advance from our plan. (This is called getting “prior authorization.” Services that require prior authorization are marked in italics in the Medical Benefits Chart in Chapter 4 of this booklet.)

It is very important to get a referral (approval in advance) from your PCP before you see a network specialist or certain other providers. (There are a few exceptions; listed above in Section 2.2 (*What kinds of medical care can you get without getting approval in advance from your PCP?*)). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

You can go to **any** network specialist listed in our *Provider Directory* provided your PCP thinks the care is appropriate. If there is a specific hospital you want to use, you will probably want to see a network specialist that is affiliated with this hospital. (For this information, you can visit our website at www.bluecrossma.com/findadoctor or you may call Member Service.)

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, you will have to switch to another provider who is part of our plan. Member Service can assist you in finding and selecting another provider. You will receive written notification at least 30 days in advance when your provider leaves the network. The letter will include special instructions on finding another provider, if appropriate.

SECTION 3 How to get covered services when you have an emergency or urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a “medical emergency” and what should you do if you have one?

A “**medical emergency**” is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You do *not* need to get approval or a referral first from your PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is on the back of your plan membership card.

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 or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Our plan also covers worldwide emergency medical care when you are traveling outside of the United States. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by

out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is “urgently needed care”?

“Urgently needed care” is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

What if you are in the plan's service area when you have an urgent need for care?

In most situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

If you are in need of urgent care and would like help finding a provider, contact Member Service (phone numbers for Member Service are printed on the back cover of this booklet).

What if you are outside the plan's service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

You may get covered emergency medical and urgent care whenever you need it, anywhere in the world. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

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

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

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

Section 4.2 If services are not covered by our plan, you must pay the full cost

Medicare HMO Blue PlusRx covers all medical services that are medically necessary, are listed in the plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network and were not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Service to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

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. The costs you pay after a benefit limit has been reached will not count toward your out-of-pocket maximum. You can call Member Service when you want to know how much of your benefit limit you have already used.

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1 What is a “clinical research study”?
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A clinical research study (also called a “clinical trial”) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has *not* approved, *you will be responsible for paying all costs for your participation in the study.*

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Member Service (phone numbers are printed on the back cover of this booklet).

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

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost sharing in Original Medicare and your cost sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.

Here's an example of how the cost sharing works: Let's say that you have a lab test that costs \$100 as part of the research study. Let's also say that your share of the costs for this test is \$20 under Original Medicare, but the test would be \$10 under our plan's benefits. In this case, Original Medicare would pay \$80 for the test and we would pay another \$10. This means that you would pay \$10, which is the same amount you would pay under our plan's benefits.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other

documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 6.1	What is a religious non-medical health care institution?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2	What care from a religious non-medical health care institution is covered by our plan?
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To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is “non-excepted.”

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
 - – *and* – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Your coverage and benefit limits for religious non-medical health care institution services are the same as for inpatient hospital care, skilled nursing facility care or home health agency care as described in the Medical Benefits Chart in Chapter 4 of this booklet.

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of Medicare HMO Blue PlusRx, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Member Service (phone numbers are printed on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

If you switch to Original Medicare after being a member of our plan: If you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare *before* you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

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

SECTION 1	Understanding your out-of-pocket costs for covered services	45
Section 1.1	Types of out-of-pocket costs you may pay for your covered services	45
Section 1.2	What is the most you will pay for Medicare Part A and Part B covered medical services?	45
Section 1.3	Our plan does not allow providers to “balance bill” you	46
SECTION 2	Use the <i>Medical Benefits Chart</i> to find out what is covered for you and how much you will pay.....	46
Section 2.1	Your medical benefits and costs as a member of the plan	46
SECTION 3	What benefits are not covered by the plan?	72
Section 3.1	Benefits we do <i>not</i> cover (exclusions)	72

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

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

Section 1.1 Types of out-of-pocket costs you may pay for your covered services
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To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **“copayment”** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **“Coinsurance”** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. (These “Medicare Savings Programs” include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs.) If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending on the rules in your state.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?
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Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of Medicare HMO Blue PlusRx, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2013 is \$3,400. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for your plan premiums and for your Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of \$3,400, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to “balance bill” you

As a member of Medicare HMO Blue PlusRx, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

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

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart on the following pages lists the services Medicare HMO Blue PlusRx covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:




- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. “Medically necessary” means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.





- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2013, either Medicare or our plan will cover those services.







You will see this apple next to the preventive services in the benefits chart.

Medical Benefits Chart


Services that are covered for you	What you must pay when you get these services
 Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” preventive visit.	You pay nothing for a Medicare-covered abdominal aortic aneurysm screening.
Ambulance services <ul style="list-style-type: none">• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person’s health) or if authorized by the plan.• Non-emergency transportation by ambulance is appropriate if it is documented that the member’s condition is such that other means of transportation are contraindicated (could endanger the person’s health) and that transportation by ambulance is medically required.	You pay a \$100 copayment each day for one or more trips (or a round trip) for Medicare-covered ambulance services. You do not pay this copayment if you are admitted as an inpatient to the hospital within 24 hours or are held overnight at the hospital for observation or for trips between hospitals and/or skilled nursing facilities (when the ambulance service meets Medicare guidelines). <i>Before you receive non-emergency ambulance services, your network provider must first obtain prior authorization.</i>
 Annual wellness visit If you’ve had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. Note: Your first annual wellness visit can’t take place within 12 months of your “Welcome to Medicare” preventive visit. However, you don’t need to have had a “Welcome to Medicare” visit to be covered for annual wellness visits after you’ve had Part B for 12 months.	There is no coinsurance or copayment for the annual wellness visit.
 Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months 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.	You pay nothing for a Medicare-covered bone mass measurement (bone densitometry). <i>You may get this service on your own, without a referral from your PCP, as long as you get it from a network provider.</i>


Services that are covered for you	What you must pay when you get these services
 Breast cancer screening (mammograms) Covered services include: <ul style="list-style-type: none">• One baseline mammogram between the ages of 35 and 39• One screening mammogram every 12 months for women age 40 and older• Clinical breast exams once every 24 months	<p>You pay nothing for Medicare-covered breast cancer screening.</p> <p><i>You may get this service on your own, without a referral from your PCP as long as you get it from a network provider.</i></p>
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	<p>You pay a \$15 copayment for each visit for Medicare-covered cardiac rehabilitation services.</p>
 Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	<p>You pay nothing for a Medicare-covered cardiovascular disease risk reduction visit.</p>
 Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	<p>You pay nothing for Medicare-covered cardiovascular screening blood tests.</p>
 Cervical and vaginal cancer screening Covered services include: For all women (including those at high risk of cervical cancer or who have had an abnormal Pap test and are of childbearing age): Pap tests and pelvic exams are covered once every calendar year.	<p>You pay nothing for covered routine Pap smear tests and pelvic exams.</p> <p><i>You may get these routine women's health services on your own, without a referral from your PCP as long as you get the services from a network provider.</i></p>

Services that are covered for you	What you must pay when you get these services
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• We cover only manual manipulation of the spine to correct subluxation	<p>You pay a \$20 copayment for each visit for Medicare-covered services.</p> <p><i>For these services, you may self refer to any plan chiropractor.</i></p>
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none">• Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months• Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none">• Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	<p>You pay nothing for Medicare-covered colorectal screening.</p> <p><i>Before you receive colorectal screening services from a specialist, you must first obtain a referral from your PCP.</i></p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <ul style="list-style-type: none">• Removal of impacted teeth that are fully or partially imbedded in the bone.• Emergency oral exams, when needed.• Routine services—limited to one initial oral exam, one periodic oral exam every 6 months, one cleaning every 6 months and one set of bitewings every 6 months.	<p>You pay a \$30 copayment for each office visit for covered dental services.</p> <p>For covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a \$150 copayment for the surgical visit.</p> <p>For Medicare-covered dental services, your coverage is described in the “Physician/Practitioner services, including doctor’s office visits” section earlier in this Medical Benefits Chart.</p> <p>Your costs for routine dental services do not count toward your maximum out-of-pocket amount.</p> <p><i>You may self refer to any network specialist or dentist for removal of impacted teeth, emergency oral exams, and for routine services.</i></p>

Services that are covered for you	What you must pay when you get these services
 Depression screening We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	You pay nothing for a Medicare-covered depression screening.
 Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	You pay nothing for Medicare-covered diabetes screening tests.
 Diabetes self-management training, diabetic services and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: <ul style="list-style-type: none">• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.• Diabetes self-management training is covered under certain conditions.• For persons at risk of diabetes: Fasting plasma glucose tests when ordered by your doctor.	You pay nothing for each Medicare-covered diabetes supply item and for Medicare-covered fasting plasma glucose tests. You pay nothing for Medicare-covered diabetes self-management training. <i>You may get this service on your own, without a referral from your PCP, as long as you get it from a network provider.</i>


Services that are covered for you	What you must pay when you get these services
<p>Durable medical equipment and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 12 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p> <p>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</p>	<p>You pay 10% of the cost for Medicare-covered items when they are supplied by a network provider.</p> <p><i>Prior authorization is required for certain durable medical equipment and related supplies. Your network provider must contact the plan prior to administering services (except emergency and urgently needed services.)</i></p> <p>Refer also to the “Diabetes self-management training, diabetic services and supplies” section in this Medical Benefits Chart for cost-sharing exceptions.</p> <p>The cost of the service, on which your liability (coinsurance) is based, will be either:</p> <ul style="list-style-type: none">• The Medicare allowable amount for covered services, or• The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none">• Furnished by a provider qualified to furnish emergency services, and• Needed to evaluate or stabilize an emergency medical condition. <p>A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.</p> <p>You have worldwide coverage for emergency care.</p>	<p>You pay a \$65 copayment for each emergency room visit. You do not pay this copayment if you are admitted to the hospital within 24 hours of the emergency room visit for the same condition, or you are held overnight at the hospital for observation.</p> <p>If your visit to the emergency room also includes outpatient hospital surgery, only your \$65 emergency care copayment applies.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan</p>

Services that are covered for you	What you must pay when you get these services
and your cost is the cost sharing you would pay at a network hospital.	
<p> Health and wellness education programs</p> <p>These are programs focused on health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, fitness, and stress management.</p> <p>Programs designed to enrich the health and lifestyles of members include weight management and fitness, including:</p> <ul style="list-style-type: none">• Fitness benefit of up to \$150 each calendar year to use toward membership or exercise classes at a health club. (The facility you choose must be a privately-owned or privately-sponsored health club or fitness facility, including individual health clubs and fitness centers, YMCAs, YWCAs, Jewish Community Centers, Council on Aging sites, and municipal fitness centers. This fitness benefit does not include country clubs, social clubs (such as hiking clubs), sports teams or leagues, spas, instructional dance studios and martial arts schools.)• Weight loss program benefit for up to \$150 each calendar year to use toward hospital-based weight loss programs or for Weight Watchers®. (This does not include on-line weight loss programs, pre-packaged meals, books, videos, scales, or other items or supplies.)	<p>You pay nothing for health education arranged through the plan's disease management programs.</p> <p>For eligible health club membership or classes, you pay any balance in excess of the \$150 limit.</p> <p>For eligible weight loss programs, you pay any balance in excess of the \$150 limit.</p> <p>(To obtain reimbursement for eligible fitness and weight loss program benefit expenses, you must submit a fitness benefit claim form and/or weight loss program claim form, as applicable, along with paid receipts. Call Member Service to request the applicable claim form. Send the completed claim form, along with the paid receipts, to Member Service.)</p> <p>Your costs for fitness and weight loss program benefits do not count toward your maximum out-of-pocket amount.</p>

Services that are covered for you	What you must pay when you get these services
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>Covered services also include:</p> <ul style="list-style-type: none">• Routine hearing exam once every 12 months and related hearing tests furnished as part of a covered hearing exam.• Hearing aids-up to \$400 every 36 months towards the cost of hearing aids, fittings, evaluations, dispensing fees, batteries and/or repairs.	<p>You pay a \$15 copayment for hearing exams by your PCP, or a \$30 copayment for hearing exams by a specialist.</p> <p>You pay nothing for related hearing tests.</p> <p>For hearing aids, you pay any balance in excess of the \$400 limit.</p> <p>For Medicare-covered hearing exams, your coverage is described in the “Physician/Practitioner services, including doctor’s office visits” section later in this Medical Benefits Chart.</p> <p>Your costs for routine hearing services (including hearing aids, fittings and evaluations), do not count toward your maximum out-of-pocket amount.</p> <p><i>You may get covered routine hearing exams and related hearing tests on your own, without a referral from your PCP, as long as you get it from a network provider.</i></p>
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none">• One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none">• Up to three screening exams during a pregnancy	<p>You pay nothing for Medicare-covered HIV screening.</p>

Services that are covered for you	What you must pay when you get these services
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)• Physical therapy, occupational therapy, and speech therapy• Medical and social services• Medical equipment and supplies	<p>You pay nothing for Medicare-covered home health agency care.</p> <p><i>Before you receive home health agency care, your network provider must first obtain prior authorization.</i></p>
<p>Home infusion therapy by a home infusion therapy provider when your prescription is written by an authorized prescriber and administered in accordance with plan guidelines. Covered services include certain intravenous medications, biologicals, intrathecal and epidural infusions, and total parenteral nutrition formulas, and the necessary supplies, equipment and skilled nursing visits to administer these medications, including but not limited to:</p> <ul style="list-style-type: none">• Antibiotics when administered by intravenous injection or infusion• Intravenous antiviral or antifungal medications• Intravenous chemotherapy agents• IVIG for certain conditions• Total parenteral nutrition when not covered under the prosthetic benefit• Biphosphonate infusions• Hydration or fluid replacement therapy• Intravenous infusion of inotropic agents (such as dobutamine)• Chelation therapy (such as Desferal®)• Enzyme replacement therapy (such as Cerezyme®, Fabrazyme®, Naglazyme®, Myozyme®)• Intravenous diuretic therapy• Anti-tumor necrosis factor therapy (such as	<p>You pay nothing for covered home infusion therapy.</p> <p><i>Before you receive home infusion therapy, your network provider must first obtain prior authorization.</i></p> <p>Refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area.</p>

Services that are covered for you	What you must pay when you get these services
<p>Remicade®)</p> <p>This coverage may exceed Original Medicare coverage guidelines.</p>	
<p>Hospice care</p>	
<p>You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.</p>	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not Medicare HMO Blue PlusRx.</p>
<p>Covered services include:</p>	
<ul style="list-style-type: none">• Drugs for symptom control and pain relief• Short-term respite care• Home care	
<p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal condition:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:</p>	
<ul style="list-style-type: none">• If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services• If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)	
<p><u>For services that are covered by Medicare HMO Blue PlusRx but are not covered by Medicare Part A or B:</u> Medicare HMO Blue PlusRx will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services.</p>	
<p>Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care</p>	

Services that are covered for you	What you must pay when you get these services
<p>through our network providers will lower your share of the costs for the services.</p> <p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	<p>You pay nothing for hospice consultation services.</p>
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none">• Pneumonia vaccine• Flu shots, once a year in the fall or winter• Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B• Other vaccines if you are at risk and they meet Medicare Part B coverage rules <p>We also cover some vaccines under our Part D prescription drug benefit.</p>	<p>You pay nothing for Medicare-covered flu shots, pneumonia and Hepatitis B vaccine. <i>For flu shots and pneumonia vaccine, you may get this service on your own, without a referral from your PCP, even if you get the service from a non-network provider.</i></p> <p>For vaccines covered under our outpatient prescription drug benefit, see Chapter 6, Section 8 (<i>What you pay for vaccinations depends on how and where you get them</i>).</p>
<p>Inpatient hospital care</p> <p>Covered services include but are not limited to:</p> <ul style="list-style-type: none">• Semi-private room (or a private room if medically necessary)• Meals including special diets• Regular nursing services• Costs of special care units (such as intensive care or coronary care units)• Drugs and medications• Lab tests• X-rays and other radiology services• Necessary surgical and medical supplies• Use of appliances, such as wheelchairs• Operating and recovery room costs• Physical, occupational, and speech language therapy• Inpatient substance abuse services• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant	<p>You pay a \$150 copayment for each day in a hospital up to a total of \$750 in each calendar year (combined with inpatient mental health admissions – see “Inpatient mental health care” below).</p> <p><i>Before you receive inpatient services (except emergency and urgently needed care), your network provider must first obtain prior authorization.</i></p> <p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.</p>

Services that are covered for you

What you must pay when you get these services


center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If Medicare HMO Blue PlusRx provides transplant services at a distant location (outside of the service area) and you chose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.


- Blood - including storage and administration. Coverage of whole blood, packed red cells, and other components of blood begins with the first pint of blood that you need.
- Physician services

Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.

You can also find more information in a Medicare fact sheet called “Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!” This fact sheet is available on the Web at <http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf> or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Services that are covered for you	What you must pay when you get these services
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay. In a free-standing psychiatric hospital, covered services are provided up to the Medicare 190-day lifetime limit. After you reach this lifetime limit in a free-standing psychiatric hospital, coverage is limited to 60 days each calendar year in a psychiatric hospital and 30 days each calendar year in a psychiatric hospital’s alcohol rehabilitation unit. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital.</p> <p>In a psychiatric unit of a general hospital, covered services are provided for as many days as are medically necessary.</p>	<p>You pay a \$150 copayment for each day in a free-standing psychiatric hospital or in a psychiatric unit of a general hospital up to a total of \$750 in each calendar year (combined with inpatient hospital admissions – see “Inpatient hospital care” above).</p> <p><i>Before you receive inpatient services (except emergency and urgently needed care), your network provider must first obtain prior authorization.</i></p>
<p>Inpatient services covered during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Physician services• Diagnostic tests (like 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	<p>You pay nothing for Medicare-covered ancillary services when inpatient hospital or SNF days aren’t covered or are no longer covered; room and board are excluded.</p> <p>You pay a \$15 copayment for each Medicare-covered visit for physical therapy, speech therapy, or occupational therapy.</p> <p><i>Before you receive physical, occupational, and/or speech language therapy services, your network provider must first obtain prior authorization.</i></p>

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next calendar year.</p>	<p>You pay nothing for each Medicare-covered visit to a licensed dietician or nutritionist.</p> <p><i>Before you receive these services, your PCP must first obtain prior authorization.</i></p>
<p>Medicare Part B prescription drugs</p> <p>These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:</p> <ul style="list-style-type: none">• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan• Clotting factors you give yourself by injection if you have hemophilia• Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug• Antigens• Certain oral anti-cancer drugs and anti-nausea drugs• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)	<p>You pay nothing for these prescription drugs. There is no benefit limit on these drugs.</p>


Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none">• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases <p>Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is explained in Chapter 6.</p>	
 Obesity screening and therapy to promote sustained weight loss <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p>	<p>You pay nothing for Medicare-covered obesity screening and therapy to promote sustained weight loss.</p>
Outpatient diagnostic tests and therapeutic services and supplies <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• X-rays• Radiation (radium and isotope) therapy including technician materials and supplies• Surgical supplies, such as dressings• Splints, casts and other devices used to reduce fractures and dislocations• Laboratory tests• Blood - including storage and administration. Coverage of whole blood, packed red cells, and other components of blood begins with the first pint of blood that you need.• Other outpatient diagnostic tests	<p>For x-rays, radiation therapy, blood, and laboratory tests, you pay nothing.</p> <p>For supplies from a hospital, physician or other provider as part of a visit, you pay the same cost-share as for the related visit.</p> <p>For CT scans, MRIs, PET scans, and nuclear cardiac imaging tests, you pay a \$100 copayment for each category of test for each service date. (This copayment does not apply to interpretation costs or when these imaging tests are performed on the same day as an emergency room visit or as outpatient day surgery.) <i>Before you receive a breast MRI (magnetic resonance imaging) or a PET (positron emission tomography) scan, your network provider must first obtain prior authorization.</i></p> <p>For other diagnostic tests, you pay nothing.</p>



Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services</p> <p>We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none">• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery• Laboratory and diagnostic tests billed by the hospital• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it• X-rays and other radiology services billed by the hospital• Medical supplies such as splints and casts• Certain screenings and preventive services• Certain drugs and biologicals that you can't give yourself <p>Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff.</p> <p>You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.</p>	<p>For outpatient emergency department services billed by the hospital, see the "Emergency care" section earlier in this Medical Benefits Chart.</p> <p>For outpatient clinic services billed by the hospital, you pay nothing for medical services. However, if your professional provider's office is located at, or professional services are billed by, the hospital, see the "Physician/Practitioner services, including doctor's office visits" section later in this Medical Benefits Chart.</p> <p>For outpatient same-day surgery services, see the "Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers" section later in this Medical Benefits Chart.</p> <p>For outpatient laboratory tests billed by the hospital, see the "Outpatient diagnostic tests and therapeutic services and supplies" section earlier in this Medical Benefits Chart.</p> <p>For outpatient mental health care services billed by the hospital, see the "Outpatient mental health care" section later in this Medical Benefits Chart.</p> <p>For partial hospitalization services, see the "Partial hospitalization services" section later in this Medical Benefits Chart.</p> <p>For outpatient x-rays and other radiology services and medical supplies (such as splints and casts) billed by the hospital, see the "Outpatient diagnostic tests and therapeutic services and supplies" section earlier in this Medical Benefits Chart.</p> <p>For screenings and preventive services, see the preventive services marked with an apple throughout this Medical Benefits Chart.</p> <p>For certain drugs and biologicals that you can't give yourself, see the "Medicare Part B prescription drugs" section earlier in this Medical Benefits Chart.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or 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.</p>	<p>You pay a \$30 copayment each visit for Medicare-covered outpatient mental health services.</p> <p><i>Before you receive mental health services (other than neuropsychological testing), prior authorization must first be obtained by calling the behavioral health and substance abuse referral toll-free number on your membership card. Your PCP can do this for you, or you can call directly, 24 hours a day, 7 days a week.</i></p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p>You pay a \$15 copayment for each visit for Medicare-covered outpatient rehabilitation services. (The Medicare benefit limit for outpatient physical therapy, occupational therapy, and speech language therapy does not apply to your benefits under our plan.)</p> <p><i>Before you receive physical, occupational, and/or speech language therapy services, your network provider must first obtain prior authorization.</i></p>
<p>Outpatient substance abuse services</p> <p>Covered services include:</p> <p>Substance abuse services provided by a state-licensed psychiatrist or 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.</p>	<p>You pay a \$30 copayment for each visit for Medicare-covered outpatient substance abuse services.</p> <p><i>Before you receive substance abuse services, prior authorization must first be obtained by calling the behavioral health and substance abuse referral toll-free number on your membership card. Your PCP can do this for you, or you can call directly, 24 hours a day, 7 days a week.</i></p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p>You pay a \$15 copayment for each office visit to your PCP, or a \$30 copayment for each office visit to a specialist.</p> <p>For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a \$150 copayment for each visit.</p> <p>(When these services are performed on the same day as an emergency room visit, you do not pay this \$150 copayment.)</p> <p><i>Before you receive services from a specialist, you must first obtain a referral from your PCP.</i></p> <p><i>Prior authorization is required for certain outpatient surgeries. Your network provider must contact the plan prior to administering services (except emergency and urgently needed services).</i></p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p>You pay nothing for Medicare-covered partial hospitalization services that are not directly provided by a physician.</p> <p><i>Before you receive partial hospitalization services, prior authorization must first be obtained by calling the behavioral health and substance abuse referral toll-free number on your membership card. Your PCP can do this for you, or you can call directly, 24 hours a day, 7 days a week.</i></p>


Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location• Consultation, diagnosis, and treatment by a specialist• Basic hearing and balance exams performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment• Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare• Second opinion by another network provider prior to surgery• 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 physician)	<p>You pay a \$15 copayment for each office visit to your PCP or a \$30 copayment for each office visit to a specialist.</p> <p>For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a \$150 copayment for the surgical visit. (For outpatient surgery, also see the "Outpatient surgery" section earlier in this Medical Benefits Chart.)</p> <p><i>Before you receive services from a specialist, you must first obtain a referral from your PCP.</i></p> <p><i>Prior authorization is required for certain outpatient services. Your network provider must contact the plan prior to administering services (except emergency and urgently needed services).</i></p> <p><i>Before you receive services from an out-of-network provider (except emergency and urgently needed care), your PCP must first obtain prior authorization.</i></p> <p>You pay nothing for each visit to any network provider for maternity services. For these services, you may self refer to any network provider.</p>
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none">• Diagnosis and the medical or surgical 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	<p>You pay a \$15 copayment for each office visit to your PCP or a \$30 copayment for each office visit to a specialist for Medicare-covered services.</p> <p>For Medicare-covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a \$150 copayment for the surgical visit. (For outpatient surgery, also see the "Outpatient surgery" section earlier in this Medical Benefits Chart.)</p> <p><i>Before you receive services from a specialist, you must first obtain a referral from your PCP.</i></p>


Services that are covered for you	What you must pay when you get these services
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none">• Digital rectal exam• Prostate Specific Antigen (PSA) test	<p>You pay nothing for Medicare-covered prostate cancer screening.</p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p>You pay 10% of the cost for Medicare-covered items.</p> <p>Refer also to the “Diabetes self-management training, diabetic services and supplies” section in this Medical Benefits Chart for cost-sharing exceptions.</p> <p>The cost of the service, on which your liability (coinsurance) is based, will be either:</p> <ul style="list-style-type: none">• The Medicare allowable amount for covered services, or• The amount either we negotiate with the provider or the local Blue Medicare Advantage plan negotiates with its provider on behalf of our members, if applicable. The amount negotiated may be either higher than, lower than, or equal to the Medicare allowable amount.
<p>Pulmonary rehabilitation services</p> <p>Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</p>	<p>You pay a \$15 copayment for each visit for Medicare-covered pulmonary rehabilitation services.</p>


Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p>	<p>You pay nothing for Medicare-covered screening and counseling to reduce alcohol misuse.</p>
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</p>	<p>You pay nothing for Medicare-covered screening for sexually transmitted infections (STIs) and counseling to prevent STIs.</p>

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease and conditions	
Covered services include:	
<ul style="list-style-type: none">• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3)• Inpatient dialysis treatments (if you are admitted as an inpatient 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) <p>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, “Medicare Part B prescription drugs.”</p>	<p>You pay nothing for Medicare-covered kidney disease education services.</p> <p>You pay nothing for Medicare-covered outpatient services.</p> <p>For inpatient dialysis treatments, your coverage is described in the “Inpatient hospital care” section earlier in this Medical Benefits Chart.</p> <p><i>Before you receive outpatient services from a specialist, you must first obtain a referral from your PCP, except for dialysis treatments when you are temporarily out of the service area.</i></p>
Skilled nursing facility (SNF) care	
(For a definition of “skilled nursing facility care,” see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)	
Medically necessary covered services are provided for up to 100 days in a benefit period. No prior hospital stay is required.	
Covered services include but are not limited to:	
<ul style="list-style-type: none">• Semiprivate room (or a private room if medically necessary)• Meals, including special diets• Skilled nursing services• Physical therapy, occupational therapy, and speech	<p>In each benefit period, you pay a \$50 copayment for each day for days 1 through 20 in a skilled nursing facility, and a \$100 copayment for each day for days 21 through 44. Then, for days 45 through 100, you pay nothing.</p> <p>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</p>

Services that are covered for you	What you must pay when you get these services
<p>therapy</p> <ul style="list-style-type: none">• Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)• Blood - including storage and administration. Coverage of whole blood, packed red cells, and other components of blood begins with the first pint of blood that you need.• Medical and surgical supplies ordinarily provided by SNFs• Laboratory tests ordinarily provided by SNFs• X-rays and other radiology services ordinarily provided by SNFs• Use of appliances such as wheelchairs ordinarily provided by SNFs• Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none">• A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).• A SNF where your spouse is living at the time you leave the hospital.	<p>to the number of benefit periods you can have.</p> <p><i>Before you receive inpatient services (except emergency and urgently needed care), your network provider must first obtain prior authorization.</i></p>

Services that are covered for you	What you must pay when you get these services
<p> Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p> <p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost sharing. Each counseling attempt includes up to four face-to-face visits.</p> <p>We cover some smoking cessation medications under our Part D prescription drug benefit.</p>	<p>If you haven't been diagnosed with an illness caused or complicated by tobacco use: You pay nothing.</p> <p>If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: You pay nothing.</p>
<p>Urgently needed care</p> <p>Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>You have worldwide coverage for urgently needed care.</p>	<p>You pay a \$15 copayment for each office visit to your PCP, or a \$30 copayment for each office visit to other providers, for urgently needed care.</p>

Services that are covered for you	What you must pay when you get these services
<p> Vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • 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. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • One pair of contact lenses needed due to keratoconus. 	<p>You pay a \$15 copayment for each office visit to your PCP, or a \$30 copayment for each office visit to other network providers.</p> <p>For covered outpatient surgery performed in a hospital or ambulatory surgical center, you pay a \$150 copayment for the surgical visit.</p> <p>You pay nothing for Medicare-covered glaucoma eye exam screenings.</p> <p>You pay nothing for Medicare-covered standard eyeglasses or contact lenses and for covered standard contact lenses for keratoconus when prescribed and filled by a Davis Vision network provider and/or another network provider.</p> <p>For help in finding a Davis Vision network provider, contact Member Service.</p>
<p>Routine vision care</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Routine refractive eye exams once every 12 months. • Prescription eyewear once every 24 months up to a \$150 maximum, including: <ul style="list-style-type: none"> – Eyeglasses: Single vision, bifocal, trifocal, or progressive spectacle lenses, and/or frames (includes fittings and dispensing fees); <i>or</i> – Contact lenses (including contact lens evaluation, fittings and dispensing fees) 	<p>For a covered routine eye exam at a Davis Vision network provider, you pay a \$30 copayment.</p> <p>For covered eyewear through Davis Vision network providers, you pay any balance in excess of the \$150 limit.</p> <p>You must use Davis Vision network providers for routine vision care and eyewear. For help in finding a Davis Vision network provider, contact Member Service.</p> <p>Your costs for routine vision care do not count toward your maximum out-of-pocket amount.</p>

Services that are covered for you	What you must pay when you get these services
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p>	<p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>
<p>Wigs</p> <p>Covered services include wigs up to \$500 per calendar year when hair loss is due to: chemotherapy, radiation therapy, or treatment of cancer or leukemia. (Our plan does not cover wigs when hair loss is due to male pattern baldness, female pattern baldness or natural or premature aging.)</p>	<p>You pay any balance in excess of the \$500 limit.</p> <p>Your costs for non-Medicare covered wigs do not count toward your maximum out-of-pocket amount.</p>

SECTION 3 What benefits are not covered by the plan?

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

This section tells you what kinds of benefits are “excluded.” Excluded means that the plan doesn’t cover these benefits.

The list below describes some services and items that aren’t covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care such as, cleanings, fillings or dentures, except as outlined in the Medical Benefits Chart earlier in this chapter. However, non-routine dental care required to treat illness or injury may be covered as inpatient or outpatient care.
- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.

- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids. However, the plan covers eyeglasses for people after cataract surgery, contact lenses needed due to keratoconus, and routine refractive eye exams and routine eyewear as described in the Medical Benefits Chart earlier in this chapter.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Taxi or chair car service.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

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

SECTION 1	Introduction	77
Section 1.1	This chapter describes your coverage for Part D drugs	77
Section 1.2	Basic rules for the plan's Part D drug coverage	78
SECTION 2	Fill your prescription at a network pharmacy or through the plan's mail-order service	78
Section 2.1	To have your prescription covered, use a network pharmacy	78
Section 2.2	Finding network pharmacies.....	78
Section 2.3	Using the plan's mail-order services.....	79
Section 2.4	How can you get a long-term supply of drugs?	80
Section 2.5	When can you use a pharmacy that is not in the plan's network?	80
SECTION 3	Your drugs need to be on the plan's "Drug List"	81
Section 3.1	The "Drug List" tells which Part D drugs are covered	81
Section 3.2	There are five "cost-sharing tiers" for drugs on the Drug List	82
Section 3.3	How can you find out if a specific drug is on the Drug List?.....	82
SECTION 4	There are restrictions on coverage for some drugs	82
Section 4.1	Why do some drugs have restrictions?	82
Section 4.2	What kinds of restrictions?	83
Section 4.3	Do any of these restrictions apply to your drugs?.....	83
SECTION 5	What if one of your drugs is not covered in the way you'd like it to be covered?	84
Section 5.1	There are things you can do if your drug is not covered in the way you'd like it to be covered.....	84
Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?.....	85

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?.....	87
SECTION 6	What if your coverage changes for one of your drugs?	87
Section 6.1	The Drug List can change during the year.....	87
Section 6.2	What happens if coverage changes for a drug you are taking?.....	88
SECTION 7	What types of drugs are <i>not</i> covered by the plan?	89
Section 7.1	Types of drugs we do not cover.....	89
SECTION 8	Show your plan membership card when you fill a prescription	90
Section 8.1	Show your membership card	90
Section 8.2	What if you don't have your membership card with you?.....	90
SECTION 9	Part D drug coverage in special situations.....	90
Section 9.1	What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?	90
Section 9.2	What if you're a resident in a long-term care facility?	90
Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?.....	91
SECTION 10	Programs on drug safety and managing medications.....	92
Section 10.1	Programs to help members use drugs safely.....	92
Section 10.2	Programs to help members manage their medications	92



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Service and ask for “LIS Rider.” (Phone numbers for Member Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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This chapter **explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 6, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs, Medicare HMO Blue PlusRx also covers some drugs under the plan’s medical benefits:

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4 (*Medical Benefits Chart, what is covered and what you pay*) tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan’s medical benefits. The rest of your prescription drugs are covered under the plan’s Part D benefits.

Section 1.2 Basic rules for the plan's Part D drug coverage

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

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

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

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

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

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.bluecrossma.com/medicare-options), or call Member Service (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask to either have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Member Service (phone numbers are printed on the back cover of this booklet) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Service.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Service (phone numbers are printed on the back cover of this booklet).

Section 2.3 Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs that are *not* available through the plan's mail-order service are marked "NMO" with an asterisk in our Drug List.

Our plan's mail-order service allows you to order **up to a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, you can go to our website (www.bluecrossma.com/medicare-options) or you can call Member Service (phone numbers are printed on the back cover of this booklet). If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than fourteen (14) days. Once the order is received by the mail-order pharmacy, your prescription(s) are processed in less than five (5) days leaving additional time for shipping. If a shipment is expected to be delayed and we have your contact information, you will receive an automated notification from the pharmacy informing you of the delay. If you contact us about your delayed order and request expedited handling, the mail-order pharmacy will work with your physician to expedite processing and delivery of your prescription(s) when appropriate.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of “maintenance” drugs on our plan’s Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Service for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use the plan’s network **mail-order services**. The drugs that are not available through our plan’s mail-order service are marked as “NMO” with an asterisk in our Drug List. Our plan’s mail-order service allows you to order up to a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan’s network?

Your prescription may be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- if the prescriptions are related to care for a plan-covered medical emergency or urgently needed care.
- if you are traveling within the United States, but outside of the plan service area, and you become ill, lose or run out of your prescription drugs and a network pharmacy is not available.
- Please be aware that our pharmacy network is extensive, and it is unlikely that you would be unable to find a network pharmacy in your area. If you are going on a trip, be sure to check your supply of any drug you take on a regular basis 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 network mail order pharmacy service or through a retail network pharmacy that offers an extended supply. Please call our Member Service or look in your Pharmacy Directory to find out which retail pharmacies offer an extended supply.
- if you are unable to get a covered drug in a timely manner within the plan 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 covered prescription drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

In these situations, **please check first with Member Service** to see if there is a network pharmacy nearby. (Phone numbers for Member Service are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1 explains how to ask the plan to pay you back.)

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

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

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

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

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

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug and usually costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 3.2 There are five “cost-sharing tiers” for drugs on the Drug List

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

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

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

The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 (*What you pay for your Part D prescription drugs*).

Section 3.3 How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (www.bluecrossma.com/formularies/medicare) The Drug List on the website is always the most current.
3. Call Member Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Service are printed on the back cover of this booklet.)

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will

need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

Section 4.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a “generic” drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will provide you the generic version.** We usually will not cover the brand name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you or has written “No substitutions” on your prescription for a brand name drug, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called “**prior authorization.**” Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

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

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 4.3 Do any of these restrictions apply to your drugs?

The plan’s Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Service (phone numbers are printed on the back cover of this booklet) or check our website [.www.bluecrossma.com/formularies/medicare](http://www.bluecrossma.com/formularies/medicare)).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you

should contact Member Service to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2 for information about asking for exceptions.)

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

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

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 5, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of five different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a drug to you when your drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply, you must meet the two requirements below:

1. The change to your drug coverage must be one of the following types of changes:

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**
We will cover a temporary supply of your drug **one time only during the first 90 days of the calendar year**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to the plan and aren't in a long-term care facility:**
We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to the plan and reside in a long-term care facility:**
We will cover a temporary supply of your drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

To ask for a temporary supply, call Member Service (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different drug covered by the plan or ask the plan to make an exception for you and cover your current drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Member Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Service are printed on the back cover of this booklet.)

You can ask for an exception

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

If you are a current member and a drug you are taking will be removed from the formulary or restricted in some way for next year, we will allow you to request a formulary exception in advance for next year. We will tell you about any change in the coverage for your drug for next year. You can then ask us to make an exception and cover the drug in the way you would like it to be covered for next year. We will give you an answer to your request for an exception before the change takes effect.

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

Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?

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

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Member Service to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. (Phone numbers for Member Service are printed on the back cover of this booklet.)

You can ask for an exception

For drugs in Cost Sharing Tier 2 (non-preferred generic) and Cost Sharing Tier 4 (non-preferred brand), you and your provider can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

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

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Cost-Sharing Tier 3 (preferred brand) or Cost-Sharing Tier 5 (specialty medications).

SECTION 6 What if your coverage changes for one of your drugs?

Section 6.1 The Drug List can change during the year

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand name drug with a generic drug.**

In almost all cases, we must get approval from Medicare for changes we make to the plan's Drug List.

Section 6.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage *for a drug you are taking*, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time.**

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand name drug at a network pharmacy.
 - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
 - Or you and your provider can ask the plan to make an exception and continue to cover the brand name drug for you. For information on how to ask for an exception, see Chapter 9 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*).
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your provider will also know about this change, and can work with you to find another drug for your condition.

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

Section 7.1 Types of drugs we do not cover
--

This section tells you what kinds of prescription drugs are “excluded.” This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

Also, by law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates, except when used to treat epilepsy, cancer, or a chronic mental health disorder

If you receive Extra Help paying for your drugs, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid

program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

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

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 7, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
--

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 6 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, *Ending your membership in the plan*, tells when you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Service (phone numbers are printed on the back cover of this booklet).

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of 31 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4 tells what to do.

Section 9.3	What if you're also getting drug coverage from an employer or retiree group plan?
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Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact **that group's benefits administrator**. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be *secondary* to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage':

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

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely
--

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

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

- Possible medication errors
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition
- Drugs that may not be safe or appropriate because of your age or gender
- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions written for drugs that have ingredients you are allergic to
- Possible errors in the amount (dosage) of a drug you are taking.

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

Section 10.2 Programs to help members manage their medications
--

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Service (phone numbers are printed on the back cover of this booklet).

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

SECTION 1	Introduction	95
Section 1.1	Use this chapter together with other materials that explain your drug coverage...95	
SECTION 2	What you pay for a drug depends on which “drug payment stage” you are in when you get the drug	96
Section 2.1	What are the drug payment stages for Medicare HMO Blue PlusRx members?...96	
SECTION 3	We send you reports that explain payments for your drugs and which payment stage you are in.....	97
Section 3.1	We send you a monthly report called the “Explanation of Benefits” (the “EOB”).....97	
Section 3.2	Help us keep our information about your drug payments up to date.....97	
SECTION 4	During the Deductible Stage, you pay the full cost of your preferred brand, non-preferred brand, and specialty medication drugs	98
Section 4.1	You stay in the Deductible Stage until you have paid \$120 for your preferred brand, non-preferred brand, and specialty medication drugs.....98	
SECTION 5	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share.....	98
Section 5.1	What you pay for a drug depends on the drug and where you fill your prescription	98
Section 5.2	A table that shows your costs for a <i>one-month</i> supply of a drug	99
Section 5.3	A table that shows your costs for a <i>long-term</i> (up to a 90-day) supply of a drug	100
Section 5.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,970	101
SECTION 6	During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 79% of the costs of generic drugs	102
Section 6.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,750.....	102
Section 6.2	How Medicare calculates your out-of-pocket costs for prescription drugs	103

SECTION 7 During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs 105

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year105

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them 105

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot.....105

Section 8.2 You may want to call us at Member Service before you get a vaccination.....107

SECTION 9 Do you have to pay the Part D “late enrollment penalty”?..... 107

Section 9.1 What is the Part D “late enrollment penalty”?.....107

Section 9.2 How much is the Part D late enrollment penalty?107

Section 9.3 In some situations, you can enroll late and not have to pay the penalty.....108

Section 9.4 What can you do if you disagree about your late enrollment penalty?.....109

SECTION 10 Do you have to pay an extra Part D amount because of your income? 109

Section 10.1 Who pays an extra Part D amount because of income?.....109

Section 10.2 How much is the extra Part D amount?110

Section 10.3 What can you do if you disagree about paying an extra Part D amount?.....110

Section 10.4 What happens if you do not pay the extra Part D amount?110



Did you know there are programs to help people pay for their drugs?

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage about the costs for Part D prescription drugs may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (also known as the “Low Income Subsidy Rider” or the “LIS Rider”), which tells you about your drug coverage. If you don’t have this insert, please call Member Service and ask for the “LIS Rider.” (Phone numbers for Member Service are printed on the back cover of this booklet.)

SECTION 1 Introduction

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

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information we give you in this chapter, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan’s *List of Covered Drugs (Formulary)*.** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the five “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Member Service (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at www.bluecrossma.com/formularies/medicare. The Drug List on the website is always the most current.
- **Chapter 5 of this booklet.** Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.
- **The plan’s *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of

pharmacies in the plan’s network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month’s supply).

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

Section 2.1 What are the drug payment stages for Medicare HMO Blue PlusRx members?

As shown in the table below, there are “drug payment stages” for your prescription drug coverage under Medicare HMO Blue PlusRx. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan’s monthly premium regardless of the drug payment stage.

Stage 1 <i>Yearly Deductible Stage</i>	Stage 2 <i>Initial Coverage Stage</i>	Stage 3 <i>Coverage Gap Stage</i>	Stage 4 <i>Catastrophic Coverage Stage</i>
<p>During this stage, you pay the full cost of your preferred brand, non-preferred brand, and specialty medication drugs.</p> <p>You stay in this stage until you have paid \$120 for your preferred brand, non-preferred brand, and specialty medication drugs (\$120 is the amount of your preferred brand, non-preferred brand, and specialty medication drug deductible).</p> <p>(Details are in Section 4 of this chapter.)</p>	<p>During this stage, the plan pays its share of the cost of your preferred generic and non-preferred generic drugs and you pay your share of the cost.</p> <p>After you (or others on your behalf) have met your preferred brand, non-preferred brand, and specialty medication drug deductible, the plans pays its share of the costs of your preferred brand, non-preferred brand, and specialty medication drugs and you pay your share.</p> <p>You stay in this stage until your year-to-date “total drug costs” (your payments plus any Part D plan’s payments) total \$2,970.</p> <p>(Details are in Section 5 of this chapter.)</p>	<p>During this stage, you pay 47.5% of the price for brand name drugs plus a portion of the dispensing fee) and 79% of the price for generic drugs.</p> <p>You stay in this stage until your year-to-date “out-of-pocket costs” (your payments) reach a total of \$4,750. This amount and rules for counting costs toward this amount have been set by Medicare.</p> <p>(Details are in Section 6 of this chapter.)</p>	<p>During this stage, the plan will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2013).</p> <p>(Details are in Section 7 of this chapter.)</p>

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the “Explanation of Benefits” (the “EOB”)

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

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**total drug costs.**” This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the “EOB”) when you have had one or more prescriptions filled through the plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Member Service (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4 During the Deductible Stage, you pay the full cost of your preferred brand, non-preferred brand, and specialty medication drugs

Section 4.1 You stay in the Deductible Stage until you have paid \$120 for your preferred brand, non-preferred brand, and specialty medication drugs
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The Deductible Stage is the first payment stage for your drug coverage. You will pay a yearly deductible of \$120 on preferred brand, non-preferred brand, and specialty medication drugs. **You must pay the full cost of your preferred brand, non-preferred brand, and specialty medication drugs** until you reach the plan's deductible amount. For all other drugs, you will not have to pay any deductible and will start receiving coverage immediately.

- Your **“full cost”** is usually lower than the normal full price of the drug, since our plan has negotiated lower costs for most drugs.
- The **“deductible”** is the amount you must pay for your Part D prescription drugs before the plan begins to pay its share.

Once you have paid \$120 for your preferred brand, non-preferred brand, and specialty medication drugs, you leave the Deductible Stage and move on to the next drug payment stage, which is the Initial Coverage Stage.

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

Section 5.1 What you pay for a drug depends on the drug and where you fill your prescription
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During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan has five cost-sharing tiers

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

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

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

Your pharmacy choices

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

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy

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

Section 5.2 A table that shows your costs for a *one-month* supply of a drug

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

- **“Copayment”** means that you pay a fixed amount each time you fill a prescription.
- **“Coinsurance”** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5 for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a *one-month* supply (or less) of a covered Part D prescription drug from:

	Network pharmacy (up to a 30-day supply)	The plan's mail-order service (up to a 30-day supply)	Network long-term care pharmacy (up to a 31-day supply)	Out-of-network pharmacy (Coverage is limited to certain situations; see Chapter 5 for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (preferred generic drugs)	\$6 copayment	\$6 copayment	\$6 copayment	\$6 copayment
Cost-Sharing Tier 2 (non-preferred generic drugs)	\$12 copayment	\$12 copayment	\$12 copayment	\$12 copayment
Cost-Sharing Tier 3 (preferred brand)	\$45 copayment	\$45 copayment	\$45 copayment	\$45 copayment
Cost-Sharing Tier 4 (non-preferred brand)	\$90 copayment	\$90 copayment	\$90 copayment	\$90 copayment
Cost-Sharing Tier 5 (specialty medications)	30% coinsurance	30% coinsurance	30% coinsurance	30% coinsurance

Section 5.3 A table that shows your costs for a *long-term* (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an “extended supply”) when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a *long-term (90-day)* supply of a covered Part D prescription drug from:

	Network pharmacy (up to a 90-day supply)	The plan's mail-order service (up to a 90-day supply)
Cost-Sharing Tier 1 (preferred generic drugs)	\$18 copayment (\$12 for a 31-60 day supply)	\$6 copayment
Cost-Sharing Tier 2 (non-preferred generic drugs)	\$36 copayment (\$24 for a 31-60 day supply)	\$24 copayment
Cost-Sharing Tier 3 (preferred brand)	\$135 copayment (\$90 for a 31-60 day supply)	\$90 copayment
Cost-Sharing Tier 4 (non-preferred brand)	\$270 copayment (\$180 for a 31-60 day supply)	\$180 copayment
Cost-Sharing Tier 5 (specialty medications)	30% coinsurance	30% coinsurance

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2,970

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$2,970 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The \$120 you paid when you were in the Deductible Stage.
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2013, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2,970 limit in a year.

We will let you know if you reach this \$2,970 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 6 During the Coverage Gap Stage, you receive a discount on brand name drugs and pay no more than 79% of the costs of generic drugs

Section 6.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,750

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 47.5% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 79% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (21%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 79% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2013, that amount is \$4,750.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of \$4,750, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Section 6.2 How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

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

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

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

It matters who pays:

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

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,750 in out-of-pocket costs within the calendar year, you will move from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Service to let us know (phone numbers are printed on the back cover of this booklet).

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

- **We will help you.** The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter tells about this report). When you reach a total of \$4,750 in out-of-pocket costs for the year, this report will tell you that you have left the Coverage Gap Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3.2 tells what you can do to help make sure that our records of what you have spent are complete and up to date.

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

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,750 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

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

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *–either–* coinsurance of 5% of the cost of the drug
 - *–or–* \$2.65 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.60 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 8 What you pay for vaccinations covered by Part D depends on how and where you get them

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends on three things:

- 1. The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.

- Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary)*.

2. Where you get the vaccine medication.

3. Who gives you the vaccination shot.

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Deductible and Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

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

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet (*Asking us to pay our share of a bill you have received for covered medical services or drugs*).
- You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration).

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

- You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine.

Section 8.2 You may want to call us at Member Service before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Service whenever you are planning to get a vaccination. (Phone numbers for Member Service are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 9 Do you have to pay the Part D “late enrollment penalty”?

Section 9.1 What is the Part D “late enrollment penalty”?

Note: If you receive “Extra Help” from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without “creditable” prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn’t have creditable prescription drug coverage. (“Creditable prescription drug coverage” is coverage that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The penalty is added to your monthly premium. When you first enroll in Medicare HMO Blue PlusRx, we let you know the amount of the penalty.

Your late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Section 9.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn’t have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2013, this average premium amount is \$31.17.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times \$31.17. This equals \$4.36, which rounds to \$4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

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

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 9.3	In some situations, you can enroll late and not have to pay the penalty
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Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
 - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
 - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
 - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
 - For additional information about creditable coverage, please look in your *Medicare & You* 2013 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving “Extra Help” from Medicare.

Section 9.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Service to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your late enrollment penalty while you’re waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 10 Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is \$85,000 or above for an individual (or married individuals filing separately) or \$170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn’t enough to cover the extra amount owed. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

Section 10.2 How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2011 was:	If you were married but filed a separate tax return and your income in 2011 was:	If you filed a joint tax return and your income in 2011 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than \$85,000	Equal to or less than \$85,000	Equal to or less than \$170,000	\$0
Greater than \$85,000 and less than or equal to \$107,000		Greater than \$170,000 and less than or equal to \$214,000	\$11.60
Greater than \$107,000 and less than or equal to \$160,000		Greater than \$214,000 and less than or equal to \$320,000	\$29.90
Greater than \$160,000 and less than or equal to \$214,000	Greater than \$85,000 and less than or equal to \$129,000	Greater than \$320,000 and less than or equal to \$428,000	\$48.30
Greater than \$214,000	Greater than \$129,000	Greater than \$428,000	\$66.60

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

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

Section 10.4 What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

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

SECTION 1	Situations in which you should ask us to pay our share of the cost of your covered services or drugs	112
Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment	112
SECTION 2	How to ask us to pay you back or to pay a bill you have received	114
Section 2.1	How and where to send us your request for payment	114
SECTION 3	We will consider your request for payment and say yes or no	115
Section 3.1	We check to see whether we should cover the service or drug and how much we owe	115
Section 3.2	If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal	115
SECTION 4	Other situations in which you should save your receipts and send copies to us	116
Section 4.1	In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs	116

SECTION 1 **Situations in which you should ask us to pay our share of the cost of your covered services or drugs**

Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment
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Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

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

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t

pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.4.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

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

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

- Please call Member Service for additional information about how to ask us to pay you back and deadlines for making your request. (Phone numbers for Member Service are printed on the back cover of this booklet.)

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Sec. 2.5 to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

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

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

- For example, the drug may not be on the plan’s *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn’t know about or don’t think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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

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

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (www.bluecrossma.com/medicare-options) or call Member Service and ask for the form. (Phone numbers for Member Service are printed on the back cover of this booklet.)

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

Blue Cross Blue Shield of Massachusetts
Member Service
P.O. Box 55007
Boston, MA 02205

You must submit your claim to us within thirteen months of the date you received the service, item, or drug from an out-of-network provider or **within twelve months** for pharmacy claims.

Contact Member Service if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4 Other situations in which you should save your receipts and send copies to us

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage and Coverage Gap Stage you can buy your drug at a **network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible Stage and Coverage Gap Stage, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

Chapter 8. Your rights and responsibilities

SECTION 1	Our plan must honor your rights as a member of the plan	118
Section 1.1	We must provide information in a way that works for you (including alternate formats such as large print).....	118
Section 1.2	We must treat you with fairness and respect at all times	118
Section 1.3	We must ensure that you get timely access to your covered services and drugs.	118
Section 1.4	We must protect the privacy of your personal health information	119
Section 1.5	We must give you information about the plan, its network of providers, and your covered services.....	120
Section 1.6	We must support your right to make decisions about your care.....	121
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made.....	122
Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?.....	123
Section 1.9	How to get more information about your rights	123
SECTION 2	You have some responsibilities as a member of the plan.....	124
Section 2.1	What are your responsibilities?.....	124

SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1 We must provide information in a way that works for you (including alternate formats such as large print)

To get information from us in a way that works for you, please call Member Service (phone numbers are printed on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in alternate formats such as large print if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2 We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Member Service (phone numbers are printed on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Service can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs
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As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Service to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10 of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first*. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

If you have questions or concerns about the privacy of your personal health information, please call Member Service (phone numbers are printed on the back cover of this booklet).

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of Medicare HMO Blue PlusRx, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in large print.)

If you want any of the following kinds of information, please call Member Service (phone numbers are printed on the back cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the *Provider Directory*.
 - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can call Member Service (phone numbers are printed on the back cover of this booklet) or visit our website at www.bluecrossma.com/findadoctor or www.bluecrossma.com/medicare-options.
- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Member Service (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to

- change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask the plan for a coverage decision.

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

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

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

The legal documents that you can use to give your directions in advance 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 use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** 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. You can also contact Member Service to ask for the forms (phone numbers are printed on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form 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. Be sure to keep a copy at home.

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

- 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.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Commonwealth of Massachusetts Board of Registration in Medicine at 1-781-876-8200 or toll free in Massachusetts at 1-800-377-0550.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Service (phone numbers are printed on the back cover of this booklet).

Section 1.8	What can you do if you believe you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

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

Is it about something else?

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

- You can **call Member Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9	How to get more information about your rights
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There are several places where you can get more information about your rights:

- You can **call Member Service** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: <http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf>.)
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Member Service (phone numbers are printed on the back cover of this booklet). We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.*
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** *Please call Member Service to let us know (phone numbers are printed on the back cover of this booklet).*
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** *Show your plan membership card whenever you get your medical care or Part D prescription drugs.*
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*
- **Pay what you owe.** *As a plan member, you are responsible for these payments:*
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
 - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
 - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** *If you are going to move, it's important to tell us right away. Call Member Service (phone numbers are printed on the back cover of this booklet).*
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- **Call Member Service for help if you have questions or concerns.** *We also welcome any suggestions you may have for improving our plan.*
 - Phone numbers and calling hours for Member Service are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

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

BACKGROUND

SECTION 1	Introduction	129
Section 1.1	What to do if you have a problem or concern.....	129
Section 1.2	What about the legal terms?.....	129
SECTION 2	You can get help from government organizations that are not connected with us.....	129
Section 2.1	Where to get more information and personalized assistance.....	129
SECTION 3	To deal with your problem, which process should you use?	131
Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?	131

COVERAGE DECISIONS AND APPEALS

SECTION 4	A guide to the basics of coverage decisions and appeals.....	132
Section 4.1	Asking for coverage decisions and making appeals: the big picture.....	132
Section 4.2	How to get help when you are asking for a coverage decision or making an appeal.....	133
Section 4.3	Which section of this chapter gives the details for <u>your</u> situation?	133
SECTION 5	Your medical care: How to ask for a coverage decision or make an appeal.....	134
Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care.....	134
Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)	135

Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)	138
Section 5.4	Step-by-step: How to make a Level 2 Appeal	141
Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?.....	142
SECTION 6	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal.....	143
Section 6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug.....	143
Section 6.2	What is an exception?.....	145
Section 6.3	Important things to know about asking for exceptions.....	146
Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception	147
Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan).....	150
Section 6.6	Step-by-step: How to make a Level 2 Appeal	152
SECTION 7	How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon	153
Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights	154
Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date.....	155
Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date.....	157
Section 7.4	What if you miss the deadline for making your Level 1 Appeal?	159
SECTION 8	How to ask us to keep covering certain medical services if you think your coverage is ending too soon.....	161
Section 8.1	<i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.....	161
Section 8.2	We will tell you in advance when your coverage will be ending	162

Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time.....	162
Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time.....	164
Section 8.5	What if you miss the deadline for making your Level 1 Appeal?	165
SECTION 9	Taking your appeal to Level 3 and beyond.....	168
Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	168
Section 9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	169

MAKING COMPLAINTS

SECTION 10	How to make a complaint about quality of care, waiting times, customer service, or other concerns	171
Section 10.1	What kinds of problems are handled by the complaint process?.....	171
Section 10.2	The formal name for “making a complaint” is “filing a grievance”	173
Section 10.3	Step-by-step: Making a complaint.....	174
Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization	175
Section 10.5	You can also tell Medicare about your complaint	175

BACKGROUND

SECTION 1 Introduction

Section 1.1	What to do if you have a problem or concern
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This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems, you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2	What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter generally says “making a complaint” rather than “filing a grievance,” “coverage decision” rather than “organization determination” or “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

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

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1	Where to get more information and personalized assistance
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Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

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

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

Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?
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If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

<p>To figure out which part of this chapter will help with your specific problem or concern, START HERE</p>
--

<p>Is your problem or concern about your benefits or coverage?</p>	
---	--

<p>(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)</p>	
--	--

<p style="text-align: center;">Yes.</p>	<p style="text-align: center;">No.</p>
--	---

<p style="text-align: center;">My problem is about benefits or coverage.</p>	<p style="text-align: center;">My problem is <u>not</u> about benefits or coverage.</p>
--	---

<p>Go on to the next section of this chapter, Section 4, “A guide to the basics of coverage decisions and making appeals.”</p>	<p>Skip ahead to Section 10 at the end of this chapter: “How to make a complaint about quality of care, waiting times, customer service or other concerns.”</p>
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COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

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

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases we might decide a service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call us at **Member Service** (phone numbers are printed on the back cover of this booklet).
- To get **free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **For medical care, a doctor can make a request for you.** Your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **For Part D prescription drugs, your doctor or other prescriber** can request a coverage determination or a Level 1 or 2 appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Service (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to 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. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

- **Section 5** of this chapter: “Your medical care: How to ask for a coverage decision or make an appeal”
- **Section 6** of this chapter: “Your Part D prescription drugs: How to ask for a coverage decision or make an appeal”

- **Section 7** of this chapter: “How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon”
- **Section 8** of this chapter: “How to ask us to keep covering certain medical services if you think your coverage is ending too soon” (*Applies to these services only*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call Member Service (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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



Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)?

If not, you may want to read it before you start this section.

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

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
 - **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility**

(CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here’s what to read in those situations:

- Chapter 9, Section 7: *How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon.*
- Chapter 9, Section 8: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?	
If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, Section 5.2.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal . (This means you are asking us to reconsider.) Skip ahead to Section 5.3 of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to Section 5.5 of this chapter.

Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)
--------------------	--

Legal Terms	When a coverage decision involves your medical care, it is called an “ organization determination. ”
--------------------	---

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.”

Legal Terms	A “fast coverage decision” is called an “expedited determination.”
--------------------	--

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard coverage decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more calendar days** if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

If your health requires it, ask us to give you a “fast coverage decision”

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received.* (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

- You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
- If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your request for coverage for medical care, you decide if you want to make an appeal.

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)
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Legal Terms	An appeal to the plan about a medical care coverage decision is called a plan “reconsideration.”
--------------------	--

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a “fast appeal.”

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care.*).

- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Service (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make a request by calling us)

Legal Terms	A “fast appeal” is also called an “ expedited reconsideration. ”
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- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.

Step 2: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to part or all of your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal,** it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The written notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5	What if you are asking us to pay you for our share of a bill you have received for medical care?
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If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see

Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

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

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

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



Have you read Section 4 of this chapter (*A guide to "the basics" of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 6.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
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Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary)*. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by

the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs (Formulary)*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs (Formulary)*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
 - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
<p>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</p> <p>You can ask us to make an exception. (This is a type of coverage decision.)</p> <p>Start with Section 6.2 of this chapter.</p>	<p>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</p> <p>You can ask us for a coverage decision.</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Do you want to ask us to pay you back for a drug you have already received and paid for?</p> <p>You can ask us to pay you back. (This is a type of coverage decision.)</p> <p>Skip ahead to Section 6.4 of this chapter.</p>	<p>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</p> <p>You can make an appeal. (This means you are asking us to reconsider.)</p> <p>Skip ahead to Section 6.5 of this chapter.</p>

Section 6.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

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

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary)*.** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a " formulary exception. "
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- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Cost Sharing Tier 4 (non-preferred brand). You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

- 2. Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to Chapter 5 and look for Section 4).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits.* For some drugs, there are restrictions on the amount of the drug you can have.
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

- 3. Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of five cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”
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- If your drug is in Cost Sharing Tier 2 (non-preferred generic) you can ask us to cover it at the cost-sharing amount that applies to drugs in Cost Sharing Tier 1 (preferred generic). If your drug is in Cost Sharing Tier 4 (non-preferred brand) you can ask us to cover it at the cost sharing amount that applies to drugs in Cost Sharing Tier 3 (preferred brand) This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in Tier 3 (preferred brand) or Cost Sharing Tier 5 (specialty medications).

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast coverage decision.” You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact us when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask us to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking us to pay our share of a bill you have received for covered medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “supporting statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast coverage decision”

Legal Terms	A “fast coverage decision” is called an “ expedited coverage determination. ”
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 of this chapter.)

Step 2: We consider your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested** –
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 6.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms	An appeal to the plan about a Part D drug coverage decision is called a plan “ redetermination. ”
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Step 1: You contact us and make your **Level 1 Appeal**. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
 - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact us when you are making an appeal about your Part D prescription drugs.*
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number shown in Chapter 2, Section 1 (*How to contact our plan when you are making an appeal about your Part D prescription drugs.*).
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in Chapter 2, Section** (*How to contact us when you are making an appeal about your part D prescription drugs.*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited redetermination. ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in Section 6.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

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

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for “fast” appeal.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 6.6 Step-by-step: How to make a Level 2 Appeal

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

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

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

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested** –
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.
 - If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for

your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

- The day you leave the hospital is called your “**discharge date**.” Our plan’s coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 7.1	During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights
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During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Service (phone numbers are printed on the back cover of this booklet). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

1. Read this notice carefully and ask questions if you don’t understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
- Where to report any concerns you have about quality of your hospital care.
- Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms	The written notice from Medicare tells you how you can “ request an immediate review .” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)
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2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)

- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.
3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Service (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.

Legal Terms A “fast review” is also called an “**immediate review.**”

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date**. (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a **“fast review”** of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

Legal Terms	A “fast review” is also called an “ immediate review ” or an “ expedited review .”
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Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms	This written explanation is called the “ Detailed Notice of Discharge. ” You can get a sample of this notice by calling Member Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or you can see a sample notice online at http://www.cms.hhs.gov/BNI/
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Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 7.3

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If

we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

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

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

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

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

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?**You can appeal to us instead**

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited appeal ”.
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Step 1: Contact us and ask for a “fast review.”

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

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

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

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says yes to your appeal**, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there

are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal**, it means they agree with us that your planned hospital discharge date was medically appropriate.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

<p>Section 8.1 <i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services</p>
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This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
 - The written notice tells you the date when we will stop covering the care for you.
 - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms In telling you what you can do, the written notice is telling how you can request a **“fast-track appeal.”** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

Legal Terms The written notice is called the **“Notice of Medicare Non-Coverage.”** To get a sample copy, call Member Service (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

2. **You must sign the written notice to show that you received it.**
 - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
 - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If

you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Service (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care.*
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

Legal Terms	This notice explanation is called the “ Detailed Explanation of Non-Coverage. ”
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Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

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

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

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
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If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

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

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

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

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

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5	What if you miss the deadline for making your Level 1 Appeal?
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You can appeal to us instead

As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited appeal ”.
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Step 1: Contact us and ask for a “fast review.”

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

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

- To make sure we were following all the rules when we said no to your fast appeal, **we are required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity. ” It is sometimes called the “ IRE. ”
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Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”
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- **If the Administrative Law Judge says yes to your appeal, the appeals process *may or may not be over*** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may or may not be over*.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may or may not* be over** - We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council’s decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

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

Level 3 Appeal A **judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the

Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **If the answer is no, the appeals process *may or may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

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



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these kinds of problems,
you can “make a complaint”**

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Service has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Service or other staff at the plan?
 - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor’s office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 10.2 The formal name for “making a complaint” is “filing a grievance”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Service is the first step.** If there is anything else you need to do, Member Service will let you know. Call Member Service at 1-800-200-4255 (TTY users call 1-800-522-1254). Calls to these numbers are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- **Your written grievance must contain:** your name, address and membership number; your signature, or that of an authorized representative, including the date on which it is signed; and a description of the specific event and the date on which it occurred. (In the event you submit a formal grievance concerning the quality of care you received from a network provider, we will contact you to obtain your permission for us to contact the provider if your permission is not included in your formal grievance. We will investigate the grievance with your permission, but the outcomes of such investigations are considered by us to be confidential. For this reason, you will not receive information about the final outcome of the investigation.) We must keep track of all grievances in order to report data to CMS and to our members, upon request.
- **Whether you call or write, you should contact Member Service right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a “fast complaint” is also called an “expedited grievance.”
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Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about Medicare HMO Blue PlusRx directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Chapter 10. Ending your membership in the plan

SECTION 1	Introduction	177
Section 1.1	This chapter focuses on ending your membership in our plan	177
SECTION 2	When can you end your membership in our plan?	177
Section 2.1	You can end your membership during the Annual Enrollment Period.....	177
Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited	178
Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period	178
Section 2.4	Where can you get more information about when you can end your membership?	179
SECTION 3	How do you end your membership in our plan?	180
Section 3.1	Usually, you end your membership by enrolling in another plan.....	180
SECTION 4	Until your membership ends, you must keep getting your medical services and drugs through our plan.....	182
Section 4.1	Until your membership ends, you are still a member of our plan.....	182
SECTION 5	Medicare HMO Blue PlusRx must end your membership in the plan in certain situations	182
Section 5.1	When must we end your membership in the plan?	182
Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health	183
Section 5.3	You have the right to make a complaint if we end your membership in our plan.....	183

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in Medicare HMO Blue PlusRx 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 only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.

- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will end when your new plan’s coverage begins on January 1.

Section 2.2	You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited
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You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of Medicare HMO Blue PlusRx may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.

- If you have MassHealth.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.
 - If we violate our contract with you.
 - If you are getting care in an institution, such as a nursing home or long-term care hospital.
 - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).
- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
 - **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
 - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Member Service** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2013* Handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.

- You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --or-- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage.) See Chapter 6, Section 9 for more information about the late enrollment penalty.

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

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare health plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare health plan. You will automatically be disenrolled from Medicare HMO Blue PlusRx when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from Medicare HMO Blue PlusRx when your new plan’s coverage begins.
<ul style="list-style-type: none"> • Original Medicare <i>without</i> a separate Medicare prescription drug plan. <ul style="list-style-type: none"> ○ Note: If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 9 for more information about the late enrollment penalty. 	<ul style="list-style-type: none"> • Send us a written request to disenroll. Contact Member Service if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact Medicare, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from Medicare HMO Blue PlusRx when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan
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If you leave Medicare HMO Blue PlusRx, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Medicare HMO Blue PlusRx must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Medicare HMO Blue PlusRx must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Service to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Service are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for a two-calendar month grace period.
 - We must notify you in writing that you have a two-calendar month to pay the plan premium before we end your membership.
- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Service** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We <u>cannot</u> ask you to leave our plan for any reason related to your health
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What should you do if this happens?

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

Section 5.3 You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Chapter 11. Legal notices

SECTION 1	Notice about governing law	185
SECTION 2	Notice about nondiscrimination	185
SECTION 3	Notice about Medicare Secondary Payer subrogation rights	185
SECTION 4	Notice about notices	185
SECTION 5	Notice about acts of providers.....	185
SECTION 6	Notice about the doctor-patient relationship.....	186
SECTION 7	Notice about disagreement with the network provider’s recommended treatment	186
SECTION 8	Notice about services in a disaster	186
SECTION 9	Notice about assignment of benefits	186
SECTION 10	Notice about time limit for legal action	186
SECTION 11	Notice about our rights to recover benefits payment	187
SECTION 12	Notice about Women’s Health and Cancer Rights	187
SECTION 13	Notice about the Blue Cross and Blue Shield Association	187

SECTION 1 Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2 Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Medicare HMO Blue PlusRx, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Notice about notices

Any notice that we give to you will be in writing and either delivered personally or by United States mail to your last address known to us. (If you are an inpatient in a hospital or a skilled nursing facility (SNF) and we need to send you a written notice of denial in response to a request for prior authorization of inpatient services, we will mail the notice to your last known address, but we will also call in the hospital or SNF. If we cannot reach you by phone, we will contact the hospital or SNF and ask the provider to tell you that the request for prior authorization was denied. We will also forward a copy of the written notice of denial to the provider via a fax for the provider to give to you.)

If you want to send a notice to us, please send it to Member Service.

SECTION 5 Notice about acts of providers

We are not liable for the acts or omissions by any individuals or institutions that furnish care or services to you. In addition, a network provider or other health care provider does not act as an agent on behalf of or for us. And, we do not act as an agent for network providers or other health care providers.

SECTION 6 Notice about the doctor-patient relationship

We do not prohibit or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on your behalf about: your health status, medical care, or treatment options; the risks, benefits, and consequences of treatment or non-treatment; and your right to refuse treatment and to express preferences about future treatment decisions.

SECTION 7 Notice about disagreement with the network provider's recommended treatment

When you enroll in our plan, you agree that your PCP and other network providers are responsible for determining the treatment that is appropriate and medically necessary for your care.

You have the right to participate fully in decisions about your health care. You may (for personal or religious reasons) refuse to accept the procedures or treatments recommended by your network provider. You have the right to refuse the treatment advice of the network provider. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave, and the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Or, you may request treatment that a network provider judges to be incompatible with generally accepted professional standards of medical care. You also have the right to seek care that is not covered by our plan. However, we will have no obligation to pay for any care obtained in these instances.

SECTION 8 Notice about services in a disaster

Our plan is not liable if events beyond the plan's control, such as war, riot, public health emergency or natural disaster, cause delay or failure to furnish covered services to members. Our plan will make a good faith effort to furnish health care or arrange for health care to be furnished in these situations.

SECTION 9 Notice about assignment of benefits

You cannot assign any benefit or monies due under our plan to any person, corporation or other organization without our written consent. Any assignment by you will be void. Assignment means the transfer of your rights to the benefits provided by our plan to another person or organization.

SECTION 10 Notice about time limit for legal action

Chapter 9 describes your rights to make an appeal or complaint for almost all kinds of claims that you may have under our plan. If you have a claim that you believe is not subject to the procedures described in Chapter 9, you must begin any legal action against us within two years after such cause of action arises.

SECTION 11 Notice about our rights to recover benefits payment

Reimbursement of Benefit Payments. If you are injured by any act or omission of another person, the benefits under our plan will be subrogated. This means that we may use your right to recover money from the person(s) who caused the injury or from any insurance company or other party. If you recover money, we are entitled to recover up to the amount of the payments that we have made. This is true no matter where or by whom the recovered money is held or how it is designated and even if you do not recover the total amount of your claim against the other person(s). This is also true if the payment you receive is described as payment for other than health care expenses. The amount you must reimburse us will not be reduced by any attorney's fees or expenses you incur.

Member Cooperation. You must give us information and help. This means you must complete and sign all necessary documents to help us get this money back. This also means that you must give us timely notice of all significant steps during negotiation, litigation, or settlement with any third party (such as filing a claim or lawsuit, initiation of settlement discussions, agreement to a settlement in principle, etc.) and before settling any claim arising out of injuries you sustained by an act or omission of another person(s) for which we provided benefits. You must not do anything that might limit our right to full reimbursement.

SECTION 12 Notice about Women's Health and Cancer Rights

Our plan includes coverage for breast reconstruction in connection with a mastectomy. These services include: all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas. These services will be furnished in a manner determined in consultation with the attending physician and the patient. (These benefits are provided to the same extent that plan coverage is provided for treatment of other medical conditions.)

SECTION 13 Notice about the Blue Cross and Blue Shield Association

This Evidence of Coverage is a contract solely between you (the member) and Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. is a corporation independent of and operating under a license from the Blue Cross and Blue Shield Association (Association). The Association permits Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. to use the Blue Cross and Blue Shield Services Marks in the Commonwealth of Massachusetts. Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. is not contracting as an agent of the Association. This contract is not based on representations by any person other than Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc. Neither the Association nor any one of the other independent Blue Cross and Blue Shield Plans licensed by the Association will be held accountable or liable to you for any of Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.'s obligations to you created by this contract.

This information does not create any additional obligations on the part of Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc., other than those obligations created under the provisions of this Evidence of Coverage.

The Blue Cross and Blue Shield Association is a trade association for independent, locally operated Blue Cross and/or Blue Shield Plans (Licensees). Neither the Association nor any one of the independent Blue Cross and Blue Shield Licensees are accountable or liable for the actions or inactions of another Blue Cross and Blue Shield Licensee.

Chapter 12. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of Medicare HMO Blue PlusRx, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.4 for more information about balance billing.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,750 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

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

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

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor’s visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription drug.

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

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn’t covered under your plan, that isn’t a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

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

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

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

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage 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).

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

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

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

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

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

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

Initial Coverage Stage – This is the stage after you have met your deductible and before your total drug expenses have reached \$2,970, including amounts you’ve paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Part B when you turn 65, your Initial

Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Institutional Special Needs Plan (SNP) – A Special Needs Plan that enrolls eligible individuals who continuously reside or are expected to continuously reside for 90 days or longer in a long-term care (LTC) facility. These LTC facilities may include a skilled nursing facility (SNF); nursing facility (NF); (SNF/NF); an intermediate care facility for the mentally retarded (ICF/MR); and/or an inpatient psychiatric facility. An institutional Special Needs Plan to serve Medicare residents of LTC facilities must have a contractual arrangement with (or own and operate) the specific LTC facility (ies).

Institutional Equivalent Special Needs Plan (SNP) – An institutional Special Needs Plan that enrolls eligible individuals living in the community but requiring an institutional level of care based on the State assessment. The assessment must be performed using the same respective State level of care assessment tool and administered by an entity other than the organization offering the plan. This type of Special Needs Plan may restrict enrollment to individuals that reside in a contracted assisted living facility (ALF) if necessary to ensure uniform delivery of specialized care.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without “creditable” prescription drug coverage.

List of Covered Drugs (Formulary or “Drug List”) – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See “Extra Help.”

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.1 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3 for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, PACE plan or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2013.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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

Member Service – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 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.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage organization has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage organization’s network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn’t have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality

care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – see “**Medicare Advantage (MA) Plan.**”

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Providers.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting “Extra Help” with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care. Urgently needed care may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Medicare HMO Blue PlusRx Member Service

CALL	1-800-200-4255 Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30. If you call after business hours, you may leave a message that includes your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. Member Service also has free language interpreter services available for non-English speakers.
TTY	1-800-522-1254 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. You can call Member Service 8:00 a.m. to 8:00 p.m. ET, 7 days a week from October 1 – February 14; and Monday through Friday from February 15 – September 30.
FAX	1-617-246-8506
WRITE	Blue Cross Blue Shield of Massachusetts Member Service P.O. Box 55007 Boston, MA 02205
WEBSITE	www.bluecrossma.com/medicare-options

SHINE “Serving the Health Information Needs of Elders” (Massachusetts’ SHIP)

SHINE is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-243-4636 Calls to this number are free.
TTY	1-800-872-0166 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	SHINE Executive Office of Elder Affairs One Ashburton Place, 5 th floor Boston, MA 02108
WEBSITE	http://www.mass.gov (then search for SHINE)

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